GATEWAY CHIROPRACTIC
120 North Cedar Street Suite 725
Charlotte, NC 28202
704-338-1960

PATIENT INFORMATION FORM, CONSENT TO TREATMENT & ASSIGNMENT

NAME ____________________________ DATE OF BIRTH _____________
Male_______________ Female_______________________

ADDRESS: ____________________________ EMPLOYER NAME_____________________

CITY _________________________________CELL PHONE # ________________________

STATE________ ZIP____________ HOME #_________________ WORK #______________

E-MAIL ADDRESS____

SPOUSE NAME ____________________________ SPOUSE WORK # __________________

EMERGENCY CONTACT NAME _________________________PHONE_______________

PHYSICIAN'S NAME _____________________________ PHONE ________________________

WHO MAY WE THANK FOR REFERRING YOU TO US? _______________________________

I here by authorize Gateway Chiropractic to examine and treat me, my dependent, or the person for whom I am signing in a representative capacity. I understand that by signing below, I am guaranteeing payment for services irrespective of any insurance coverage or benefits.

I assign all benefits or proceeds otherwise payable to me from any insurance I may have or which may be payable to me including but not limited to, health insurance, liability or medical payments insurance, or Workers Compensation to this office up to the amount of the bill for the services provided, or any other bill I may have with this office.

I further authorize this office to release any information acquired in the course of the patient's treatment to my insurance carrier, my attorney, or any other party necessary to file claims for the payment of the outstanding bill(s). I further authorize this office to obtain any information contained in the patient's previous medical history or records from other care providers if needed in the course of treatment.

I understand and agree that if collection efforts are necessary to obtain payment on this account I will be responsible for all costs of such collection efforts, including reasonable attorney fees, and interest at the legal rate will accrue on any balance remaining Ninety (90) days after discharge.

I direct any person or corporation having notice of this assignment including but not limited to, my attorney(s), insurance company personnel, tort-feasors, or any other person having proceeds from any insurance policies to pay directly to this office, in its name only, the amount shown as outstanding and owing prior to any distribution to me.

I irrevocably waive my rights under N.C.G.S. 44-49 and 44-50, and direct my attorney, or any successor attorney to pay to Gateway Chiropractic from any judgment or settlement proceeds held in trust, the entire amount owed Gateway Chiropractic, regardless of whether adherence to the foregoing statutes would result in payment of a lesser amount.

I understand the liability insurance (person at faults insurance) and my medical payments insurance will be the primary sources of payment for services rendered at this office. My health insurance will be filed as a courtesy. The clinic will accept its usual and customary charges. No special discounts will be accepted because of contracts with the insurance carrier.

This assignment is made without prejudice to any rights to compensation for injuries incurred by the patient.

Witness my seal and signature below.

____________________________ ____ (SEAL)
DATE **PATIENT SIGNATURE OR PARENT/GUARDIAN/GUARANTOR**

SS# OF PATIENT/PARENT HERE **PLEASE PRINT PATIENTS NAME HERE**