

PATIENT INFORMATION - AUTHORIZATION FOR TREATMENT AND INFORMATION  
RELEASE- ASSIGNMENT OF MEDICAL BENEFITS

Federal regulations require that a medical history must be included in all patients medical records.

(PLEASE PRINT)

Today's Date \_\_\_\_\_

Patient's Name: Last \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

Street Address: \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_ Zip \_\_\_\_\_ Home Phone #: (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_ Cell or Alternate Phone #: (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Sex: M F Student? F/T, P/T, NO Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Marital Status: Single \_\_\_\_ Mar \_\_\_\_ Div \_\_\_\_ Sep \_\_\_\_ Wid \_\_\_\_ Spouse's Name: \_\_\_\_\_

Employer: \_\_\_\_\_ Work #: (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_ Occupation: \_\_\_\_\_

Referring Dr.: Last \_\_\_\_\_ First \_\_\_\_\_ Ph. #: (\_\_\_\_)\_\_\_\_

Address: \_\_\_\_\_ Suite \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Primary Ins. Co.:** \_\_\_\_\_ Insured Name: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group/Claim #: \_\_\_\_\_ Insurer's S.S.# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Secondary Ins Co. :** \_\_\_\_\_ Insured Name: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group/Claim #: \_\_\_\_\_ Insured's S.S.# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Work Related Injury?** Y \_\_\_\_ N \_\_\_\_ **Auto Accident?** Y \_\_\_\_ N \_\_\_\_ **Other?** \_\_\_\_\_

Please Describe: \_\_\_\_\_

Date of Injury or Onset of Illness: \_\_\_\_\_

As of the beginning of this year, have you had any previous physical / chiropractic / occupational / speech or acupuncture therapy? Y \_\_\_\_ N \_\_\_\_

If yes, Where? \_\_\_\_\_ How many visits? \_\_\_\_\_ Diagnosis? \_\_\_\_\_

**CANCELLATION POLICY**

Patients will be charged \$40.00 for appointments cancelled less than two (2) hours prior to their scheduled appointment and patients that are scheduled on Saturday are required to cancel at least twenty-four (24) hours in advance.(This fee is the **patient's responsibility**, as most insurance companies do not cover this fee.)

Initial \_\_\_\_\_

**ASSIGNMENT OF MEDICAL BENEFITS**  
Authorization for Treatment and Information Release

**(PLEASE PRINT)**

Today's Date: \_\_\_\_\_

Please read and sign: I hereby authorize any insurance benefits payable by my insurance policy to go directly to Mariner's. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Mariner's will prepare any necessary reports to assist me in making collections from the insurance company. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment (Workers Compensation patients exempt). I hereby authorize this office to begin treatment as prescribed by my physician and to release information necessary to process insurance claims.

The above information is correct and true to the best of my knowledge.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian's Signature if Minor: \_\_\_\_\_ Date: \_\_\_\_\_

**MED PAY PATIENTS**  
Non-Work Related Motor Vehicle Accident

In the event I sign an Assignment of Benefits for an attorney or any other party, I hereby undertake the full amount of any outstanding balance due to Mariner's for my treatment. I understand the balance is due immediately and that I am to notify Mariner's of any changes to my account.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian's Signature if Minor: \_\_\_\_\_ Date: \_\_\_\_\_