APOLLO CHIROPRACTIC
HEALTH AND WELLNESS, LLC

6911 Taylor Ranch Road NW, STE C-8Albuquerque, NM 87120
Phone: (505) 792-3311; email: apollo-chiro@comcast.net

NEW PATIENT REGISTRATION MVA/PI CLAIM

Today's Date _____ Referral Source: _____

Name _____
Last First MI

Address

_____
(Complete Mailing) Street Apt# City State Zip

Date of Birth_____ Age_____

Primary Phone* (_____) _____ - _____ ☐ home ☐ cell ☐ work

Secondary Phone* (_____) _____ - _____ ☐ home ☐ cell ☐ work

Email Address for Newsletter: _____

Employer_____ Occupation_____ Phone (_____) _____ - _____

Emergency Contact_____ Relationship_____ Phone (_____) _____ - _____

* Please notify our front office staff if there is an alternate address / phone number or form of communication that you wish us to contact you by other than your listed information above.

I have read and understand that this alternative is available to me _____
Signature

MVA INFORMATION FOR OFFICE USE ONLY

INSURANCE: _____

CLAIM NUMBER: _____CONTACT: _____

DATE OF ACCIDENT: _____

PHONE NUMBER: _____ FAX NUMBER: _____

ADDRESS: _____

_____

NOTE: The Guarantor assumes the responsibility to pay charges for services and products received at Apollo Chiropractic Health and Wellness, LLC.

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ACKNOWLEDGEMENT AND UNDERSTANDING

PLEASE READ AND INITIAL EACH ITEM BELOW.

1. _____ I hereby authorize the Apollo Chiropractic Health and Wellness, LLC, to provide Chiropractic services for me and or my minor aged child.

2. _____ If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collections.

3. _____ I authorize release of patient's records to third parties requiring these records for determination of financial liability and/or treatment.

4. _____ I certify that the information I have reported in regards to my insurance is correct and up to date.

5. _____ I have provided a Copy of my Driver's License for patient's chart.

6. _____ I understand that I am financially responsible for all charges whether or not paid by insurance.

7. _____ I have read and agree to the **Assignment of Benefits** and **No Show Cancel Appointment** below.

Assignment of Benefits to a Provider

An assignment of benefits is an arrangement by which a patient requests that his or her health insurance payments be made to a designated person or facility, such as Apollo Chiropractic Health and Wellness LLC. If, by chance, the insurance company does not directly pay Apollo Chiropractic but the patient, the patient is responsible for payment of treatment within 5 business days of receiving the insurance check. If payment to Apollo Chiropractic is not made within 5 business days, Apollo Chiropractic will be paid a surcharge of 1% per calendar day payment is late based on amount owed for product and services.

No Shows and or Cancellation less than 24 Hours

A fee of $50.00 per scheduled provider

By signing this application, I affirm under penalty that I have given true complete information.

_____ _____

Patient Signature Date

_____ _____

Guarantor Signature Relationship to Patient