

TOTAL HEALTH WELLNESS CENTER

10224 SW Park Way, Suite A Portland, OR 97225 ph: 503.297.1174 fax: 503.297.2623

Kelly Hubbard, D.C. In Yu, DAOM, LAc Jeannine Corey, L.M.T. Fran Rodriguez, L.M.T

PATIENT INFORMATION (Please fill in every space)

Last Name	First Name	MI	Gender M/F	How did you hear about us?
Street Address	City	State & Zip Code	Marital Status?	
Home Phone	Cell Phone	Work Phone	Email Address(s)	DOB
Employer's Name	Occupation	Emergency Contact	Emergency Contact #	

PRIVATE HEALTH INSURANCE (Please complete section fully)

Name of Insured & Employer	Insured DOB	Relationship to Insured
Insured Address and phone # if different from patient	Insurance Company	

AUTO INSURANCE (Complete if you were in an auto accident. We MUST bill Auto Insurance of the car you were in)

Name of Insured	Ins. Co. Name & Claims Address	Social Security #	
Claim #	Policy #	Date of Accident	Driver's License #

WORKMEN'S COMPENSATION INSURANCE (Complete if you had a work-related accident. This information can be obtained from your Employer.)

Employer's Name	Employer's Address	Employer's Phone #
Employer's Insurance Carrier Name & Address	Claims Phone #	
Claim #	Date of Accident	Social Security #

RECORDS RELEASE (Please read and sign)

I hereby authorize the release of any medical or other information necessary to process my claim for medical benefits. I authorize my Insurance Company to issue payment directly to this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.	
Patient or Parent/Legal Guardian for patient under 18 years of age	Date
Witness's Signature	Date

TOTAL HEALTH WELLNESS CENTER at Cedar Hills

10224 SW Park Way, Suite A Portland, OR 97225 ph: 503.297.1174 fax: 503.297.2623

Chiropractic • Acupuncture • Homeopathic • Massage Therapy

Dr. Hubbard, D.C. In Yu, DAOM, LAc Jeannine Corey, L.M.T. Fran Rodriguez, L.M.T.

FINANCIAL RESPONSIBILITY AGREEMENT

Policy:

1. All patients not covered by insurance must pay at time of service.
2. All co-pays, deductibles, and balances will be collected at the time of service.
3. In those cases where your insurance company denies payment, you are responsible for costs incurred. Payment is expected before the end of the billing month.
4. Any balances due to Total Health Wellness Center Providers after your insurance carrier has notified the Clinic of payment or non-payment will be billed to you. After thirty (30) days of the first bill, a finance charge of \$2.50 per month will begin to apply to your account. Any bill over ninety (90) days past due will be subject to collection procedures.

If you need to make payment arrangements, you can do so by contacting our Billing office. Once you agree to a payment plan, you will sign on your agreement. All payment agreements must be followed through within the allocated timeline.

We reserve the right to agree, or not, to payment plans, as they are not a guaranteed service of our clinic.

I, _____ (patient’s name or name of parent/legal guardian or responsible/legal party) as a patient of Total Health Wellness Center, acknowledge and agree to the above statements and understand that a part or all of my care may not be a covered benefit of my health plan. I acknowledge and agree to be financially responsible for my treatment.

Signature of Patient or Parent/Legal Guardian/Responsible Party

Patient’s Printed Name

Date _____