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Howard Chiropractic LLC  
808 White River Blvd.  
Muncie, In 47303  
NEW CONDITION/ ACCIDENT

Date \_\_\_\_\_  
ID# \_\_\_\_\_

**Information About You:**

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_

Called Name \_\_\_\_\_ Suffix (Jr. Sr. III IV Dr.) Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex(M) (F)

Street Address \_\_\_\_\_ City \_\_\_\_\_ State Zip \_\_\_\_\_  
(\_\_\_\_) \_\_\_\_\_ - (\_\_\_\_) \_\_\_\_\_ - (\_\_\_\_) \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Social Security # \_\_\_\_\_  
Single Married Widow Divorced Student: Full/ Part Time \_\_\_\_\_ Employed: Full - Part Time Retired \_\_\_\_\_  
School \_\_\_\_\_ Work Status \_\_\_\_\_

Employer \_\_\_\_\_ Street Address \_\_\_\_\_ City \_\_\_\_\_ State Zip \_\_\_\_\_

Referred By / Yellow Pages/ web/other Street Address \_\_\_\_\_ City \_\_\_\_\_ State Zip \_\_\_\_\_  
E-Mail Address \_\_\_\_\_ OK to leave messages at Home Y N Work Y N

Spouse/Parent Name if Student \_\_\_\_\_ Street Address \_\_\_\_\_ City \_\_\_\_\_ State Zip \_\_\_\_\_  
(\_\_\_\_) \_\_\_\_\_ - (\_\_\_\_) \_\_\_\_\_ - (\_\_\_\_) \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Birth Date \_\_\_\_\_  
(\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

Person we should call in case of emergency Relationship \_\_\_\_\_ Home Phone \_\_\_\_\_ Work/ Cell Phone \_\_\_\_\_  
Can you relate this visit to a specific cause? Y N If Yes, Describe \_\_\_\_\_

Doctor Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Insurance Information: Do You Have Insurance Y N Health Savings Acc't**  
What Type: Major Med Medicare Medicaid Work Comp Auto Med Pay General Motors  
Is Insurance through your employer Y N Parent/Spouse Employer Y N  
Please give us your Driver's License and Insurance card to copy. Spouse/ Parent \_\_\_\_\_ Date of Birth \_\_\_\_\_

**ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION**

I assign payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 16%. I/we agree that in event of default of payment, reasonable attorney fees shall be added to the amount due on the account, plus any applicable attorney and/or collection fees.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Signature \_\_\_\_\_ Date \_\_\_\_\_