Journey Through Healing Chiropractic Center, LLC

830 Saginaw Street South
Salem, OR 97302
Tel 503-480-0200 Fax 503-480-0203
journeythroughhealingchiropractic.com

Patient information

Last Name First Name MI	Previous Name	Date of Birth	Age	Sex
Street Address City State Zip		Primary Phone H / C ?		
Mailing Address (if different)		Other Phone		
EMAIL	Confidential? ☐ Yes ☐ No	Appointment Reminder Preference?		
Primary Care Physician / Clinic		Phone		
Employer	Occupation	Work Phone		
Employer Address City State Zip				
Emergency Contact	Relationship	Phone		
How did you hear about us?				

Insurance Information

Primary Insurance Company	Phone #	*ID #*	*Group #*
Subscriber	*Date of Birth*	*Relationship*	*Phone #*
Secondary Insurance Company	*Phone #*	*ID #*	*Group #*
Subscriber	*Date of Birth*	*Relationship*	*Phone #*

My initials beside the following indicate my understanding and consent

_____ I have been given written information regarding my rights and responsibilities as a patient, I understand that I am ultimately responsible for all charges on my account and that my insurance is billed as a courtesy to me by the staff at Journey Through Healing Chiropractic Center, LLC.

______ I have read and understand / declined a copy of the Patient Privacy Policy.

Assignment of Benefits

I hereby authorize Journey Through Healing Chiropractic Center, LLC to furnish the insured's company(ies) all information which said insurance company(ies) may request concerning my present claim. I hereby assign to Journey Through Healing Chiropractic Center, LLC all monies to which I am entitled for expenses related to the services performed, but not to exceed my indebtness to Journey Through Healing Chiropractic Center, LLC. It is understood that all monies received from the above names insurance company(ies) over and above my indebtness will be refunded to said insurers when my bill is paid in full. I understand that I am financially responsible to Journey Through Healing Chiropractic Center, LLC for charges not covered by this assignment.

______________________________	______________________________	______________
Patient / Responsible Party's Signature	Print your Name	Date