NEW PATIENT INTAKE FORM

PLEASE PRINT AND COMPLETE ALL ENTRIES			
FIRST NAME	LAST NAME		DATE OF BIRTH _______/_______/_______
SEX ❑ Male ❑ Female	SOCIAL SECURITY	PHONE NUMBER	EMAIL ADDRESS
ADDRESS			
CITY		STATE	ZIP CODE
MARITAL STATUS ❑SINGLE ❑MARRIED	SPOUSES NAME		SPOUSE PHONE NUMBER
EMERGENCY CONTACT	RELATIONSHIP		PHONE NUMBER

Text Message Consent

ProBody Chiropractic would like to send you appointment reminders and follow-ups via text message to ensure you receive timely updates about your care.

☐ By checking this box, I agree to receive texts from 407-255-8177 at this mobile number. Message and data rates may apply. Text STOP to unsubscribe from these alerts at any time. Text HELP or call 407-225-8177 to be contacted by our support team. See out privacy policy at https://probodyflorida.com/privacypolicy”

☐ I do not give my permission to receive text messages.

Signature: ______________________ **Date:** _____________

INSURANCE INFORMATION		
DO YOU HAVE INSURANCE? ❑YES ❑NO	PRIMARY CARD HOLDER ❑SELF ❑SPOUSE. ❑PARENT. ❑OTHER__________	PRIMARY POLICY HOLDER NAME
PRIMARY INSURANCE COMPANY	PRIMARY ID NUMBER	PRIMARY GROUP NUMBER
DO YOU HAVE SECONDARY INSURANCE? ❑YES ❑NO	SECONDARY CARD HOLDER ❑SELF ❑SPOUSE. ❑PARENT. ❑OTHER__________	SECONDARY POLICY HOLDER NAME
SECONDARY INSURANCE COMPANY	SECONDARY ID NUMBER	SECONDARY GROUP NUMBER

PAYMENT POLICIES

- You are financially responsible for anything insurance does not cover. All copays are due and payable at each visit. The amount your insurance will allow and pay for and your financial responsibility is determined by your insurance company and the policy you have chosen. Your claim will be processed according to the benefits of your insurance plan. The deductible, co-insurance and co-pay are your financial responsibility. It is your responsibility to understand your insurance plan.
- $5 Fee for Co-pays not paid at the time of service.
- $50 No Show Fee for any Missed Appointment that was not cancelled or rescheduled 24 hours prior to the appointment. Please be considerate and call at least 24 hours before your appointment if you cannot come in.
- $35 NSF charge for any returned check from the bank.
- If you are a private patient without insurance, all charges are due at the time of the visit. We do not send a statement to private pay patients.

PRESCRIPTION POLICY

PHARMACY NAME	PHARMACY PHONE NUMBER