79 West Main Street
East Palestine, Ohio 44413
330-426-2700

Patient Information

Full Name ______________________ DOB ______________ Circle: M F Marital Status: M S W D

Address ______________________City/State/Zip______________________ Email______________________

Phone ______________Alt Phone ______________ Have you ever been under Chiropractic care? Y N Who?__________

Occupation:______________ Family Physician ______________ Emergency Contact______________________

Social security number ______________ Chief Complaint______________________

Are your present conditions related to, or the result of an auto collision, work-related injury or other personal injury? __Yes or __No

Responsible Party Information

Name ______________________________________ Relationship to Patient ______________________

Address (if different) ____

Phone ______________________ DOB ______________________ Marital Status ______________________

Employer ____

Primary Insurance Information

Insurance Company ______________________ Name on Policy ______________________

Relationship to Patient ______________________ Date of Birth ______________________

Policy ID Number ______________________ Group Number ______________________

Secondary Insurance Information

Insurance Company ______________________ Name on Policy ______________________

Relationship to Patient ______________________ Date of Birth ______________________

Policy ID Number ______________________ Group Number ______________________

Patient Agreement and Assignment of Benefits: I hereby assign Dailey Chiropractic, Inc. all benefits to which I am entitled from all private and public medical insurance plans including Medicare and Medicaid. I understand I am financially responsible for all treatment charges for services rendered by Dailey Chiropractic, Inc. regardless of any limitations of insurance coverage, divorce agreements, or victim's assistance. I understand I must pay all copayments and deductibles in full. I understand I will be charged for appointments missed unless 24 hours' notice is given to Dailey Chiropractic, Inc. I understand all deductibles and copayments must be paid in full at each visit/service. I understand that my coverage is part of a contractual agreement between Dailey Chiropractic, Inc. and a specific third party payer. Dailey Chiropractic, Inc. agrees to abide by the regulations and reduced rates outlined in those contracts. I hereby agree to the above and thus authorize Dailey Chiropractic, Inc. to release information about my condition and treatment to those who are part of the process of securing insurance payment for same. I acknowledge that a photo copy of this assignment and authorization is as valid as the original. If I do not sign this agreement, I will pay for each service in full at each visit.

Signature of Insured/Responsible Party: ______________________________ **Date:** ______________

AND

Signature of Patient/Parent/Guardian: ______________________________ **Date:** ______________

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Credit/Debit/HSA Card Preauthorization Form
For Chiropractic Treatment, Missed Appointments, and/or Past Due Balances

Your credit card information is needed for the following events:

- If you miss more than one appointment without providing 24 hours' advance notice, you will be charged $25 for the missed appointment fee. This fee may not be submitted to insurance.
- If you have an outstanding balance past 120 days, I will notify you in writing that your card will be charged for the outstanding balance within 15 days if you do not call this office to make full or partial payment or set up an agreed upon payment plan.
- For copayments, deductibles, or if you are paying out of pocket for services, I can charge for each visit. You may also pay via cash or check at each appointment.

I hereby authorize Dailey Chiropractic, Inc. to keep my credit or debit card and signature on file and charge my listed credit card for recurring charges of $25 for missed appointments in which I have not provided 24 hours' notice and for any balances 120 days past due (unless I have made alternative, agreed upon arrangements with Dr Laura R Dailey Wise).

I authorize Dailey Chiropractic, Inc. to keep my signature on file and charge my listed credit card for my copayment. I authorize Dailey Chiropractic, Inc. to charge for additional associated fees as discussed at each appointment (i.e., payment of deductible or coinsurance as claims are remitted to Dr. Laura R Dailey Wise).

I understand this form is valid for one year unless I cancel the authorization in writing. I promise not to dispute charges ("charge back") for sessions I have received or that I have not cancelled with 24 hours' advance notice. I further authorize Dailey Chiropractic, Inc. to disclose information about my attendance/cancelled session(s) to my credit card issuer if I dispute the charge(s).

Patient Name ________________________________

Cardholder Name ________________________________

Cardholder Billing Address

____

Card Number ____________________________________ **Expiration Date** ________________

CVV/Security Code __________

Cardholder Signature ____________________________________ **Date** ________________

Update Patient Information

We are in the process of updating our records to comply with federal standards, please answer the following questions:

Name: ______________________________ Date: ______________

Smoking Status?

Current every day smoker

Current some day smoker

Former smoker

Never smoker

Do you have any medication allergies?

No known medication allergies

Yes. What? ____

Are you currently taking any medications?

Not currently prescribed any medications

Yes...

What? ______________________ _____ mg

What? ______________________ _____ mg

What? ______________________ _____ mg

Height ______________

Weight ______________

Blood Pressure __________

ChiroHealthUSA
The Network That Works for Chiropractic!

ChiroHealthUSA Plus

DISCOUNT MEDICAL PLAN APPLICATION

THIS FORM SHOULD NOT BE GIVEN TO PATIENTS UNLESS THEY ARE JOINING CHIROHEALTHUSA OR CHIROHEALTH PLUS
You must read important disclosures and sign the reverse side

Date:

Patient Name:

Primary Card Holder Gender: ◯ Male ◯ Female

Primary Card Holder Date of Birth:

Dependents' Names:
(Spouse, Domestic Partner, Dependent Children up to age 26, Parents in the Household over age 60, and any other IRS Dependent)

Patient Address:

City:

State: **Zip:**

Phone:

Email:
(Contact information will not be shared, sold or distributed)

FOR CLINIC USE ONLY
City:
Date entered in Online Membership Link:
By:

ChiroHealthUSA
120 Stone Creek Blvd., Suite 100, Flowood, MS 39232
1-888-719-9990

◯ *CHUSA PROCESSED*

PAYMENT INFORMATION

◯ YES! I want ChiroHealthUSA PLUS for $89.00 for a ONE YEAR membership to include Chiropractic, Vision, Dental, Pharmacy, Lab and Imaging Discounts! NOTE: Not available in Alaska, California, Vermont and Washington.

◯ YES! I want ChiroHealthUSA for discounted Chiropractic Care Only for $49.00 for a ONE YEAR membership.

You may renew your agreement by continuing annual payments as applicable for your plan. The brochure for your program contains a description of the benefits you will receive and is incorporated by reference and is a part of this document. PLEASE READ YOUR BROCHURE BEFORE SIGNING THIS DOCUMENT.

HSA and FSA accounts for payment of membership fees is not permissible.

Check and Credit card information will be destroyed once transaction is completed.

Check #:

Credit Card Type: ◯ Visa ◯ MC ◯ Amex ◯ Disc. **Card#:**

Card ID (CVV2/CID) Number: **Exp. Date:** **Billing Zip Code:**

Name on Card: **Signature:**

DISCLOSURES

These discount medical, health, and drug plans are NOT insurance, health insurance policies, Medicare Prescription Drug Plans or qualified health plans under the Affordable Care Act. These plans (The Plans) provide discounts for certain medical services, pharmaceutical supplies, prescription drugs or medical equipment and supplies offered by providers who have agreed to participate in The Plans (ChiroHealthUSA provides discounts only on chiropractic services). The range of discounts for medical, pharmacy or ancillary services offered under The Plans will vary depending on the type of provider and products or services. The Plans do not make and are prohibited from making members' payments to providers for products or services received under The Plans. The member is required and obligated to pay for all discounted prescription drugs, medical and pharmaceutical supplies, services and equipment received under The Plans, but will receive a discount on certain identified medical, pharmaceutical supplies, prescription drugs, medical equipment and supplies from providers in The Plans (ChiroHealthUSA provides discounts only on chiropractic services). Members will have free access to providers without restrictions such as waiting periods, notification periods, etc. except for hospital discounts. The Plans do not offer discounts on hospital services. The Discount Medical Plan Organization is Alliance HealthCard of Florida, Inc., P.O. Box 630858, Irving, TX 75063. ChiroHealthUSA members may call 1-888-719-9990 for more information or visit www.chirohealthusa.com for a list of providers. ChiroHealthUSA Plus members may call 1-800-220-7752 for more information or visit www.chirohealthusaplus.com for a list of providers. The Plans will make available before purchase and upon request, a list of program providers and the provider's city, state and specialty, located in the member's service area. Alliance HealthCard of Florida, Inc. does not guarantee the quality of the services or products offered by individual providers. The fees for The Plans are specified in the membership agreement. You have the right to cancel your membership at anytime. If you cancel your membership within 30 days of the effective date, you will receive a full refund of your membership fees other than money paid by you to a provider. To cancel your ChiroHealthUSA Plan you must, verbally or in writing, notify ChiroHealthUSA at 1-888-719-9990, 120 Stone Creek Blvd., Suite 100, Flowood, MS 39232. To cancel your ChiroHealthUSAPlus Plan you must, verbally or in writing, notify Alliance HealthCard of Florida, Inc. at 1-800-220-7752, P.O. Box 630858, Irving, TX 75063. Any complaints should be directed to Alliance HealthCard of Florida, Inc. at the address or phone number above. Upon receipt of the complaint, member will receive confirmation of receipt within 5 business days. After investigation of the complaint, Alliance HealthCard of Florida, Inc. will provide member with the results and a proposed resolution no later than 30 days after receipt of the complaint.

Note to DE, IL, LA, NE, NH, OH, RI, SD, TX and WV consumers: If you remain dissatisfied after completing the complaint system, you may contact your state department of insurance . You may contact Alliance HealthCard of Florida, Inc. for department of insurance contact information.

Note to MA consumers: The plan is not insurance coverage and does not meet the minimum creditable coverage requirements under M.G.L. c. 111M and 956 CMR 5.00

Signature:

ChiroHealthUSA
120 Stone Creek Blvd., Suite 100 Flowood, MS 39232
1-888-719-9990

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