MT HOPE
CHIROPRACTIC AND WELLNESS

1174 Mount Hope Ave
Rochester, NY 14620
p. 585.445.8584 e. mhcwny@gmail.com

Patient Information

Date_____

Name _____ DOB ___/___/____ Home / Cell Phone:_____

Address _____ City _____ State____ Zip code_____

Gender_____ Marital Status_____ Email_____ Primary Physician_____

Employment Status: ☐ Full time ☐ Part time ☐ Retired ☐ Self Employed ☐ Student ☐ No Employment

Employer _____ Work Phone_____

Emergency Contact_____ Phone_____

Is your injury the result of a work or automobile accident? ☐ Yes ☐No

*If NO skip to Insurance Information

Worker's Compensation/MVA information

*If Worker's comp, WCID: _____

Date of Incident ___/___/___ Insurance Carrier _____ Case ID _____

Insurance Address _____ City _____ State____ Zip _____

Phone _____ Carrier Contact _____ext._____ fax_____

Claims Adjuster_____ph._____fax_____

Please provide contact information for any other medical provider working on your case: _____

_____

Insurance Information

*If you are the subscriber, you do not need to complete subscriber information

Primary Insurance_____ Member ID_____

Effective Date_____ Name of Subscriber_____ DOB___/___/____

Relationship to patient: ☐ Parent ☐ Spouse ☐ Other

Address for subscriber if different than above: _____

Financial Agreement

I authorize payment of my insurance benefits to Mt Hope Chiropractic. In addition, I agree to pay my financial responsibility. I understand that deductibles, copays, and co-insurance dues are to be paid at the time of service. If not paid on the date of service, it is understood that an additional fee of $10 may be added to my account, unless prior financial agreements have been agreed upon. It is understood that I am responsible for any fees for service through this office that are not covered by my insurance.

Signature _____ Date_____