



Cowan Chiropractic Clinic, P.C.
Dr. John S. Cowan, B.S., D.C.
April Cowan, certified personal trainer
6507 Town Center Dr., Suite F
Clarkston, MI 48346
248-625-7600

New Patient Consultation

Today's Date _____

Tell us about yourself:

Name _____ Residence phone _____

Address _____ Cellular or secondary # _____

City _____ State _____ Zip _____

Date of Birth _____ SS# _____

Sex M F Marital Status S M D W # of children _____

Spouse's Name _____ Spouse's Date of Birth _____

How did you hear about our office (referred by): _____

Tell us about your occupation and health insurance:

Employer _____ Work Phone # _____

What is your job position? _____

Name of primary insurance _____ Name of secondary insurance _____

What brings you to our office today?

Describe Major Complaints: _____

How long have you had this problem? _____ How did it start? _____

What other Doctor's have you seen for this condition _____

When? _____ Treatment prescribed _____

Is your problem the result of a work accident? Yes No Auto Accident? Yes No

What medications are you currently taking? _____

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on both sides of this form and have completed the above questions. I certify that this information is true and correct to the best of my knowledge. I will notify Cowan Chiropractic Clinic, P.C. of any changes in my health status or the above information.

Patient Signature _____ Date _____

Parent (If minor) _____ Date _____

Authorization, Assignment and Release

_____**AUTHORIZATION TO RELEASE INFORMATION:** You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster, in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you and I hereby release you of any consequence thereof.

_____**ASSIGNMENT OF PAYMENT:** My attorney and/or insurance company are hereby requested to pay direct to the doctor listed below, any monies due him on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay the difference if any, between the total amount of his charges and the amount paid him by the attorney and/or insurance company. It is further understood that I, the undersigned, agree to pay the full amount of his charges, should my condition be such that it is not covered by my policy or if for any reason the insurance company and/or attorney refuses to pay my claim.

_____**MEDICARE ASSIGNMENT:** I authorize any holder of medical or other information about me to release the Social Security Administration and Health Care Financing Administration of its' intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

_____**GENERAL X-RAY RELEASE: KNOW ALL MEN BY THESE PRESENTS:** That I, _____ have requested the release of X-rays which are part of the office records of John S. Cowan, D.C./Cowan Chiropractic Clinic, P.C. relating to my case, and I hereby acknowledge receipt of these X-ray films. In consideration of the foregoing, I hereby release and forever discharge the aforesaid John S. Cowan, D.C./Cowan Chiropractic Clinic, P.C. from any and all responsibility or liability of any kind, nature or character whatsoever from the beginning of the world to this day. This transaction is consummated at my specific request.

_____**CONSENT TO CARE FOR MINOR CHILD:** I hereby authorize Dr. John S. Cowan; D.C. and whomever he may designate as his assistants to administer Chiropractic care as he deems necessary to my relative:_____.

Acknowledgement And Understanding

I hereby acknowledge that I am receiving (or about to receive) health care services at the Cowan Chiropractic Clinic, P.C. and that I have been advised that the doctor providing the services is willing to wait for payment for these services, provided that there continues to be a reasonable chance that payment will be made either by the insurance proceeds or out of the settlement of a liability case.

I understand that if it is determined either:

- A. That there is no insurance company obligated to pay for the services, or if the insurance company involved refuses to Acknowledge an assignment to the doctor; or make other provisions for the protection of the interest of the doctor;
- Or
- B. if a liability claim exists and my attorney refuses to agree to protect the interest of the doctor, or if I have not engaged Services of an attorney:

then payment of services rendered by the doctor at the Cowan Chiropractic Clinic, P.C. will be made on a current basis and my bill paid in full as soon as my liability claim is settled or the passage of three months from my last treatment, whichever occurs first.

Dated the _____ day of _____, 20_____

Patient's Signature

Witness