



Georgia Sports Chiropractic

Specializing in Athletic Injuries

Dr. Josh H. Glass

Certified Chiropractic Sports Practitioner®

Referred By: _____

Please Print Clearly

Today's Date: _____

Name: _____
Last First MI

Preferred Name to be called by: _____ Email: _____

Address: _____
Street City State Zip

DOB: _____ Age: _____ Sex: _____ SSN#: _____ - _____ - _____

Please check a box for the preferred # to call to confirm or reschedule appointments:

Home# _____ Cell# _____ Work# _____

Occupation: _____ Employed By: _____

Name of Closest Relative not residing with you: _____

Relationship: _____ Phone# _____

Date and Nature of Injury for this problem:

Were you previously treated for an earlier occurrence of this same condition/problem?

Any previous Accident or Illness:

- I hereby authorize Dr. Josh Glass to release any medical information pertinent to my treatment to my insurance company or physician.
- I understand that I am responsible for payment of services. If this is a treatment from an accident I am responsible for full and final payment of any charges not covered by either med pay or health insurance.
- I authorized Dr. Josh Glass, DC to examine me and treat me.

Signature _____ Date _____

Authorization and Releases

Name: _____

Consent for Treatment

I, the undersigned, hereby authorize Dr. Josh Glass and whomever he may designate as his assistant to perform diagnostic tests, and to administer treatment as is necessary.

I, also, certify that no guarantee or assurance has been made to the results that may be obtained.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that my amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account.

HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICE RENEDED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

Patient Signature

Date

Witness

Authorization to Release Medical Information

I authorize Dr. Josh Glass to release any medical information pertinent to my treatment plan to my insurance company or an authorized representative for review. This authorization for release of information shall remain valid for the term of my overage under my current policy. I certify that all insurance information given to this clinic is correct and complete. I also know that I am entitled to receive a copy of this authorization form.

Patient Signature

Date

Witness

Request for Payment of Benefits to Provider of Care

I hereby authorize the _____ Insurance Company/ Insurance Administrator to pay by check, and for it to be mailed directly to: Georgia Sports Chiropractic the expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

Patient Signature

Date

Witness