# Bend Osteopathic Care, PC

*147 SW Shevlin Hixon Dr. Suite 204, Bend OR 97702*
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www.BendOsteopathicCare.com

***Demographics***

Todays Date: _____________ Patient Name: _____________________________________________ Age: ____________ ☐M ☐F

Birth Date: ___/____/____ Hm Ph: _______________Cell Ph:_______________ Email Address: ________________________________

Physical Address: _____________________________________________ City: _________________ State: _______ Zip Code:_________

Mailing Address (If different from above): ______________________________________________________________________________

Occupation: ___________________________ Employer: __________________________ Work Phone: ______________________

May we contact you at Work: ☐Y ☐N ☐N/A **How Did You Learn/Hear About Our Practice**: ____________________________

Emergency Contact: _____________________________ Relationship: ___________________ Contact Tel#s: ___________________

Primary Care Physician: _____________________________________________________ PCP Phone: ___________________________

## *Financial & Insurance Information:*

Please **Tick** appropriate box: ☐I will pay my balance in full at time of service. ☐Please bill my insurance; I will present my card

Primary Insurance Co: _______________________________ ID#: _________________________ Group#_______________________

Secondary/Insurance Co: ___________________________________ ID#: _______________________ Group#____________________

**Complete the following about *Insured*** if not self**:** Name: _____________________________ ☐M ☐F Birth Date: ____/_____/____

Address: __________________________City: __________ State: _____ Zip: ________ Relationship to Insurer: ☐Spouse/Partner ☐Child

**Complete if Motor Vehicle Accident or Workers Compensation is to be billed:**

Insurance Co Responsible for Claim: _________________________ Claim Number:________________ Date Injured:_______________

Adjuster's Name:__________________________ Ph:___________________ Fax:_______________ Email: _____________________

## *Records Release & Assignment of Insurance Benefits:*

The undersigned hereby authorizes the **Release of Information** relating to claims for benefits submitted. **I agree and acknowledge that I authorize my physician to submit claims for benefits to appropriate insurance company, for services rendered, without obtaining my signature on each claim.**

I (Patient Name, **Pls Print**): ____________________________ Hereby authorize (Your Insurance Co. Name): ________________________________
to pay and assign directly to Bend Osteopathic Care, PC all owed benefits. I understand I am financially responsible for <u>all</u> charges incurred if my insurance does not pay.

_______________________________________________ ________________________________ __________________

**Patient Signature** (or Guardian Signature for patients under 18 Yrs) **Are you the Patient ☐<u>Yes</u> or ☐<u>Other</u>** **DATE**

## *Consent Form & Agreement:*

Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. These complications may include, but are not limited to soreness, inflammation, soft tissue injury, dizziness, and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side effects and complications is available upon request. It is also our policy to inform you of the procedure being performed and the risks and alternative treatments available. If your physician/practitioner does not explain to your satisfaction, please ask for more information. I have read and understand the above statements regarding treatment side effects and I also understand that there is no guarantee for a specific cure or result.

_______________________________________________ ________________________________ __________________

**Patient Signature** (or Guardian Signature for patients under 18 Yrs) **Are you the Patient ☐<u>Yes</u> or ☐<u>Other</u>** **DATE**