MFNC
MINNESOTA FUNCTIONAL
NEUROLOGY & CHIROPRACTIC

Jeremy Schmoe DC DACNB FACFN

5601 Chicago Ave S Minneapolis MN 55417
PHONE 612.223.8590 FAX 612.395.5261
WEB www.minnesotafunctionalneurology.com

Patient Information

File Number:

Last Name:			First Name:		Middle Initial:
Date of Birth:	Age:		Gender: male: female:		
Street Address:					
City:			State:	Zip Code:	
Home Phone #:	Work Phone #:		Cell Phone #:		
Name of Emergency Contact:	Phone Numbers & Address of Emergency Contact:			Relationship:	

Authorizations

I authorize Dr. Jeremy Schmoe to treat me ____initial

I authorize all payments to be made directly to Dr. Jeremy Schmoe on the day of service. I consent to the release of all information the insurance company may request for filing their claims. I understand that I am responsible for billing my insurance company, but many insurance companies do not cover all charges and that I am responsible for and will pay for all charges on the date of services provided by Dr. Jeremy Schmoe ____initial

I have received and reviewed the handout called Privacy Practices Notice. I understand that I can ask for further information if needed ____initial

Another practitioner referred me to Dr. Schmoe. I authorize Dr. Schmoe to send a report of his findings to ____initial

Practitioners Name: ________________________________

Discipline: ________________________________

Phone Number: ________________________________

Our primary relationship is with you, the patient, not the insurance company. Given that we accept your case, our recommendations will be based upon what your needs are & what we believe is best for you.

I understand and agree to the following:
There is no guarantee that my health insurance plan or policy will pay for all or part of my care. As the patient or guardian of a patient, I am ultimately responsible for all charges incurred from services rendered at Schmoe Chiropractic Clinic LLC.

Patient's signature (*or guardian's signature*): ________________________________. Date:__________

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