# ASPEN SPORTS CHIROPRACTIC AND ACUPUNCTURE

**ASPEN LEAF CHIROPRACTIC P.C.**
**DR. ERIC A. HAYNIE, D.C.**
**DR. ASHLEY N. WELCH, D.C.**
**616 EAST HYMAN AVE ASPEN, CO. 81611**
**BILLING ADDRESS:**
**P.O. BOX 1029 ASPEN, CO. 81612**
**(970) 544-1995,(970) 925-1808,(970)-925-140**
**(970) 925-1424, FAX (970)-920-6535**
**TIN# 84-1487460**

CONFIDENTIAL PATIENT INFORMATION

NAME:______________________________________________________________ DATE:_______________________
FIRST MIDDLE LAST NAME YOU PREFERRED TO BE CALLED

CURRENT OR MAILING ADDRESS_____________________________________________________________________
STREET CITY STATE ZIP

HOME OR PERMANENT ADDRESS_____________________________________________________________________
STREET CITY STATE ZIP

HOME PHONE:_______________________ CELL: ___________________________ WORK: ___________________________

DATE OF BIRTH: ____/____/_____SOCIAL SECURITY:____________________ EMAIL:_______________________________

EMPLOYER:_______________________________________OCCUPATION:______________________________________

EMPLOYER ADDRESS:____________________________________________________________________________

EMERGENCY CONTACT:_________________________________ PHONE #_____________________________________

WAS INJURY DUE TO AN ACCIDENT? AUTO_____WORK______OTHER______CLAIM NUMBER__________________________

DATE OF INJURY________________ADJUSTER________________________ADJUSTERS PHONE NUMBER__________________

DESCRIPTION OF PROBLEM_________________________________________________________________________

**WHOM MAY WE THANK FOR REFERRING YOU?**_____________________________________________________
**OUR POLICY**:

**•PAYMENT IS DUE ON DATE OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. WE WILL PROVIDE YOU WITH RECEIPTS FOR INSURANCE REIMBURSEMENT.**

**•We are in network with the following insurance companies: Cigna, Cofinity, Aetna, Humana, Worker's Comp**

**•We do ACCEPT Medicare and will bill it for you, but you must pay up front with the understanding you may or may not be FULLY reimbursed. WE WILL reimburse you what ever medicare or your secondary supplemental pays us.**

**•ALL ORTHOTICS REGARDLESS OF WHO YOUR INSURANCE IS MUST BE PAID FOR WHEN YOU ARE MOLDED OR CASTED. YOU WILL BE CHARGED FOR THE CASTING AND FITTING APPOINTMENTS SEPARATELY.**

**PLEASE READ AND SIGN:**

**I HEREBY STATE THAT THE ABOVE INFORMATION IS CORRECT AND COMPLETE. I AUTHORIZE ASPEN SPORTS CHIROPRACTIC TO EXAMINE ME, TAKE X-RAYS, IF NECESSARY, AND PROVIDE TREATMENT IN ACCORDANCE WITH THE STATE STATUES FOR THE CARE AND MANAGEMENT OF MY CONDITION. I ALSO UNDERSTAND THAT IF I SUSPEND OR TERMINATE MY CARE & TREATMENT, ANY FEES FOR PROFESSIONAL SERVICES WILL BE IMMEDIATELY DUE AND PAYABLE.**
**MEDICAL RELEASE OF INFORMATION: I authorize the release of any medical information necessary to aspen sports chiropractic to process this claim.**

**GUARDIAN'S SIGNATURE**________________________________**RELATIONSHIIP** ______________________________**DATE**________________
**PARENT/GUARDIAN'S SIGNATURE AUTHORIZING CARE(IF PATIENT IS A MINOR)**

**PATIENT'S SIGNATURE**_______________________________________________**DATE**______________________