Dr. Todd Just/Just Chiropractic
430 Mid Rivers Dr. St. Peters, MO 63376 Phone 636-278-2030

Welcome
The doctor and staff of **Just Chiropractic** welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care, we will not accept you as a patient but will refer you to another health care provider, if appropriate.

Name___________________________________Called Name ____
Address____
City____State_________Zip___________________
Home Phone____________________________________Work Phone__________________________________
Cell Phone__________________________________E-mail____
Date of Birth _____/____/_____ SS#____ Sex M - F
Employer____Occupation______________________________
Circle one- Married, Single, Widowed, Divorced Name of Spouse__________________________________
Insurance Company________________________Subscriber_________________Date of Birth_____/____/____
Family Physician_____________________________Authorize report to Family Physician Yes or No
Referred by____
Contact in case of emergency, Name:____
Telephone #____
Name of Parent of Minor (if applicable)____

Insurance

This office will process your insurance forms upon request. We will do our utmost to provide sufficient information to your carrier to obtain payment for your treatment. We have found that, in some instances, however, insurance companies will deny or reduce payment despite our best efforts to demonstrate the necessity for care. **In the event that full payment is not made for any reason, you understand that certain services are not reimbursable by your insurance/Medicare and that you will be responsible to make payment in full.**

Payment Terms

Fees for services rendered are due at the time of service. Services that are in network will require payment as negotiated with each individual contract.

HIPPA Privacy Policy

Attached with the patient information packet is the HIPPA Notice of Privacy Practices Policy. By signing below, the patient acknowledges that he/she has received the HIPPA Policy and that he/she understands and will comply with our financial policies.

Authorization and Assignment

In consideration of your undertaking to care for me, I agree to the following:
You are authorized to release any information you deem appropriate concerning my physical, emotional, and/or health history to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred. I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services. I further agree that this Authorization and Assignment is irrevocable until all moneys owed to Dr. Todd W. Just are paid in full.

I have read the above policies. I understand and agree to these policies.

Signature____Date _____________________________________