SUPPLEMENTAL INJURY INFORMATION

(*Please fill out completely*)

Name (first, last):_____Accident Date:_____ ***Police Report Required for Auto Accidents***

Accident type: ☐ Auto* ☐ Workers Comp ☐ Personal Injury ☐ Other_____

Address:_____City:_____State:_____Zip Code:_____

Mobile Phone#: (_____)_____Date of Birth:____/____/____ Gender: ☐ Male ☐ Female

---

Responsible Insurance Carrier/Payer:_____Claim#:_____

Agent Name(s):_____Phone#: (_____)_____

Address for Claims:_____City:_____State:_____Zip Code:_____

Insured: ☐ Self ☐ 3rd Party ☐ Parent/Guardian* Insured's Full Name:_____

If insured is Parent/Guardian or other Responsible Party they must also read and sign below.

Insured's Date of Birth:_____Address:_____

City:_____State:_____Zip Code:_____Phone#: (_____)_____

Thank you for choosing Blue Feather Family Chiropractic as your healthcare provider. This is an addendum to the New Patient Payment Arrangement (NPPA) and does not supersede that arrangement but is in addition to the NPPA and is based on extended medical care the above patient is seeking including, auto accident(s), worker's compensation claims or other medical necessities authorized. The medical services you seek imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full for the services you receive. If someone else (parent, spouse, domestic partner, etc.) is financially responsible for your expenses or carries your insurance, they must also read, understand and sign this document. By signing below and/or by receiving medical services from Dr. Terri A. Hamilton and Blue Feather Family Chiropractic, you agree:

1. *You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. You are responsible for deductibles, co-payments, co-insurance amounts or any other patient responsibility indicated by your insurance carrier or our financial policies including, "No Show" fees, charges for returned checks, any costs associated with collection of patient balances, which are not otherwise covered by supplemental insurance.*
2. *You are responsible for knowing your insurance policy and providing complete details of your insurance policy and claim information.*
3. *Cancellation policy: 24 hours advance notice of scheduled appointment cancellations or rescheduling is required. If notification to cancel has not been received a "No Show" fee will apply. The "No Show" fee will be charged directly to the patient's account, and will be billed to the patient accordingly.*

Once I have signed this agreement, whether by original, facsimile or electronic (PDF) signature, I agree to all of the terms and conditions contained herein and the agreement shall be in full force and effect.

_____	_____	_____
Patient Signature	Date	Date of Birth
_____	_____	_____
Responsible Party/Parent/Guardian Signature	Date	Date of Birth