# JOSEPH KORNFELD, D.C., D.A.B.C.N.

*Doctor of Chiropractic*

*Diplomate American Board of Chiropractic Neurology*

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Today's date: ------/-------/------

Name: ------------------------------------------------

Address: Street ______________________________

City ____________ State _____ Zip________

Phone: Home: ( )________ Work: ( )__________ Cell ( )__________

E-Mail: ______________@__________

Birth date: ____/____/____ Age: ___

Social Security #: ________-______-________

Marital status: Single___ Married ___ Divorced ___ Seperated ___ Widowed___

Health Insurance Company________________ID#________________

Who is your medical doctor (MD)?________________________

MD address________________________________

May we contact your MD? Yes____ No____

How did you find out about our office?________________________

Is condition due to an accident? Yes_____ No____

Date of Accident ____/_____/_____

Type of accident Auto____ Work____ Home_____ Other______

If Auto, who is your Insurance co.?____________________

Attorney Name (if applicable) ____________________________

CONSENT FOR CHIROPRACTIC SERVICES

I________________________________, authorize the performance upon myself the recommended examination, x-rays and treatment for my condition in accordance with the policies of the office of Dr. Joseph Kornfeld.

EXAMINATION, X-RAY AND/OR TREATMENT

I realize that these procedures are to be performed by Dr. Joseph Kornfeld.

I understand that x-rays are harmful to the unborn fetus and should notify Dr. Kornfeld if I am pregnant or even if there is the remote possibility of being pregnant.exists.

I acknowledge that no guarantee or assurance as to the results that may be obtained from the procedure has been given by Dr. Kornfeld. I understand that I am directly responsible for performing instructed procedures given by Dr, Kornfeld and that non-compliance could effect the results of my therapy.

___/___/______ ________________________________

DATE SIGNATURE

FOR PARENT OF MINOR
CONSENT TO EXAMINE, TREAT AND/OR X-RAY OF MINOR CHILD

I hereby authorize Dr. Joseph Kornfeld to examine, x-ray if deemed necessary and administer treatment that Dr. Kornfeld deems necessary to my son/ daughter____________________________.

___/___/______ ________________________________

DATE SIGNATURE OF PARENT OR GUARDIAN

ASSIGNMENT AND RELEASE

!, The undersigned have insurance coverage with BC/BS_____, HMO BLUE____,
Harvard Vanguard_____, Tufts______, Medicare_____, MassHealth_____,
_______________________Insurance Company and assign directly to Dr. Kornfeld all
medical benefits, if any, otherwise payable to me for services rendered. I understand
that ! am financially responsible for all changes whether or not paid by insurance. I
hereby authorize the doctor to release all information necessary to secure the payment
of benefits. I authorize the use of this signature on all my insurance submissions. I
authorize my insurance carrier to release any and all information to Dr. Kornfeld for the
purpose of collecting all reimbursement owed to him as a result of services rendered to
me.

THANK YOU FOR FILLING OUT OUR FORMS. THIS INFORMATION CAN BE VERY
HELPFUL. IS THERE ANYTHING ELSE THAT WE NEED TO KNOW ABOUT YOU SO
THAT WE CAN GIVE YOU OUR BEST EFFORT AND OBTAIN THE BEST POSSIBLE
RESULTS? IF SO, PLEASE LETS US KNOW.

X________________________________________________________________
Signature

X_______________
Date