

SAVE TIME!

FILL OUT THIS
FORM ONLINE AT
OUR WEBSITE

ROSQUIST

405 South 100 East, Suite 104
Pleasant Grove, Utah 84062
www.rosquistchiro.com



CHIROPRACTIC

Dr. Bryon L. Rosquist

801-785-9411

drrosquist@rosquistchiro.com

PERSONAL INFORMATION

Last Name Middle Birth Date
First Name SS# Phone
Address
City State Zip
Email Male Female Married Single Minor
Referred By Newspaper Insurance Yellow Pages Sign Other

EMPLOYMENT INFORMATION

Employer Phone
Address
City State Zip

SPOUSE'S INFORMATION

Name Birth Date
Employer SS# Phone
Address
City State Zip

ACCOUNT GUARANTOR (IF OTHER THAN THE PATIENT)

Name SS#
Relationship Phone
Address
City State Zip

INSURANCE INFORMATION

Primary Provider Phone
Address
City State Zip
Policy Holder Patient Spouse Guarantor Other: Name
Policy Group Birth Date SS#
Has your deductible been met? Yes No Not Sure Was your condition due to an injury? Yes No
If yes, was the injury Work Related Auto Accident Other Injury Date

EMERGENCY INFORMATION

Name of nearest relative not living with you
Relationship Phone
Address
City State Zip

Signature

Date

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FINANCIAL DISCLOSURE

INSURANCE PATIENTS

Co-payment and deductible payments are due at the time of service, unless arrangements have been made with our staff.

As a chiropractic care provider, our relationship is with you, not your insurance company. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select services they will not cover. Our fees are considered customary and reasonable by most companies.

Auto insurance and worker compensation generally cover 100% of the treatments rendered. Certain items, such as vitamins, are not usually covered.

NON-INSURED PATIENTS

Non-Insured patients must pay at the time of the service.

ADDITIONAL FEES

Returned checks and balances older than 30 days may subject to additional fees and interest charges of 1.5% per month.

ACKNOWLEDGMENT AND AUTHORIZATION

I hereby assign all medical benefits to Dr. Bryon Rosquist, Rosquist Chiropractic, and/or Pleasant Grove Sports Medicine. ***However, I understand that I am financially responsible for all charges whether or not paid by insurance.*** I hereby authorize said assignee to release all information necessary to secure payment as requested by my insurance company, attorney, or another physician. I realize that should my account become delinquent, it will be referred to a collection agency and there will be a charge of 33.3% to cover the collection fee. If it becomes necessary to litigate for payment, I will be charged a 50% litigation fee.

I acknowledge that I have read and understand the above financial policy.

SIGNATURE

DATE