PATIENT INFORMATION FORM

1) Patient Number _____ (Office Use Only) 2) Date ____/____/____

4) First Name _____ 5) MI ____ 6) Last Name_____ Phone ( )_____

Address _____
Street City State Zip

7) Age _____ 8) Sex _____ Birthdate ____/____/____ Marital Status (S M W D) Spouse Name _____

Social Security # ____-____-____ Occupation _____ Employer _____

Work Phone ( )_____ Work Address _____

Who referred you to our office _____ How will you be paying for today's visit? (Circle One): Cash Check Credit Card

If you have insurance which covers chiropractic care, please provide the following information and present your insurance ID card:

Type of Insurance: (Private ____ Group ____ HMO ____ Workers Comp ____ Auto ____) Your policy #_____

Name of Insured _____ Relationship to Patient _____ SS# ____/____/____

Insurance Co. _____ Group # _____

If their will be an attorney involved with this case, please provide the following information:

Attorney Name _____ Phone ( ) _____

Attorney Address _____

What is your major complaint? _____ **When did your symptoms appear?**_____

9) Is this condition due to an: A) Auto Accident B) Work Injury C) Other Accident D) Unknown Cause

10) Are the symptoms: A) Improving B) Getting Worse C) About the Same D) Intermittent (Comes & Goes)

11) What activities aggravate your condition: A) Standing B) Walking C) Sitting D) Lying E) Bending F) Lifting G) Twisting H) Coughing

12) Have you had these symptoms before? (Y / N) If so, when? _____

13) Have you seen another doctor for this condition? A) M.D. B) Chiropractor C) Osteopath D) Acupuncturist E) Dentist F) Podiatrist

Drs. Name _____ Date Consulted ____/____/____ Diagnosis _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

Patient's Signature _____ Date _____

Personal Health History

All information will be kept strictly confidential. Your responses will help determine if chiropractic treatment will benefit you. Unless we sincerely feel that your condition responds satisfactorily to treatment, we will not recommend treatment.

Name	Birth Date	Age	Today's Date	Case Number

Please check the degree of all conditions which you have or have had. We need your complete health report before we can be responsible for your case.

I = Irregular R = Regular S = Steady

Muscle / Joint

I	R	S	
☐	☐	☐	Arthritis
☐	☐	☐	Bursitis
☐	☐	☐	Foot trouble
☐	☐	☐	Hernia
☐	☐	☐	Low back pain
☐	☐	☐	Lumbago
☐	☐	☐	Neck pain, stiffness
☐	☐	☐	Pain between shoulders

General

I	R	S	
☐	☐	☐	Allergy
☐	☐	☐	Chills
☐	☐	☐	Convulsions
☐	☐	☐	Dizziness
☐	☐	☐	Fainting
☐	☐	☐	Fatigue
☐	☐	☐	Fever
☐	☐	☐	Headache
☐	☐	☐	Loss of sleep
☐	☐	☐	Loss of weight
☐	☐	☐	Nervousness, depression
☐	☐	☐	Neuralgia
☐	☐	☐	Numbness
☐	☐	☐	Sweats
☐	☐	☐	Tremors

Cardiovascular

I	R	S	
☐	☐	☐	Hardening of arteries
☐	☐	☐	High blood pressure
☐	☐	☐	Low blood pressure
☐	☐	☐	Pain over heart
☐	☐	☐	Poor circulation
☐	☐	☐	Rapid heartbeat
☐	☐	☐	Slow heartbeat
☐	☐	☐	Swelling of ankles

Genitourinary

I	R	S	
☐	☐	☐	Bed-wetting
☐	☐	☐	Blood in urine
☐	☐	☐	Frequent urination
☐	☐	☐	Lack of kidney control
☐	☐	☐	Kidney infection
☐	☐	☐	Painful urination
☐	☐	☐	Prostate trouble
☐	☐	☐	Pus in urine

Eye, Ear, Nose and Throat

I	R	S	
☐	☐	☐	Asthma
☐	☐	☐	Colds
☐	☐	☐	Crossed eyes
☐	☐	☐	Deafness
☐	☐	☐	Dental decay
☐	☐	☐	Earache
☐	☐	☐	Ear discharge
☐	☐	☐	Ear noise
☐	☐	☐	Enlarged glands
☐	☐	☐	Enlarged thyroid
☐	☐	☐	Eye pain
☐	☐	☐	Failing vision
☐	☐	☐	Far sightedness
☐	☐	☐	Gum trouble
☐	☐	☐	Hay fever
☐	☐	☐	Hoarseness
☐	☐	☐	Nasal obstruction
☐	☐	☐	Near sightedness
☐	☐	☐	Nose bleeds
☐	☐	☐	Sinus infection
☐	☐	☐	Sore throat
☐	☐	☐	Tonsilitis

Gastrointestinal

I	R	S	
☐	☐	☐	Belching or gas
☐	☐	☐	Colitis
☐	☐	☐	Colon trouble
☐	☐	☐	Constipation
☐	☐	☐	Diarrhea
☐	☐	☐	Difficult digestion
☐	☐	☐	Bloated abdomen
☐	☐	☐	Excessive hunger
☐	☐	☐	Gallbladder trouble
☐	☐	☐	Hemorrhoids
☐	☐	☐	Intestinal worms
☐	☐	☐	Jaundice
☐	☐	☐	Liver trouble
☐	☐	☐	Nausea
☐	☐	☐	Pain over stomach
☐	☐	☐	Poor appetite
☐	☐	☐	Vomiting
☐	☐	☐	Vomiting of blood

Skin

I	R	S	
☐	☐	☐	Boils
☐	☐	☐	Bruise easily
☐	☐	☐	Dryness
☐	☐	☐	Hives or allergy
☐	☐	☐	Itching
☐	☐	☐	Skin eruptions (rash)
☐	☐	☐	Varicose veins

Pain or numbness in

I	R	S	
☐	☐	☐	Shoulders
☐	☐	☐	Arms
☐	☐	☐	Elbows
☐	☐	☐	Hands
☐	☐	☐	Hips
☐	☐	☐	Legs
☐	☐	☐	Knees
☐	☐	☐	Feet
☐	☐	☐	Painful tailbone
☐	☐	☐	Poor posture
☐	☐	☐	Sciatica
☐	☐	☐	Spinal curvature
☐	☐	☐	Swollen joints

Respiratory

I	R	S	
☐	☐	☐	Chest pain
☐	☐	☐	Chronic cough
☐	☐	☐	Difficult breathing
☐	☐	☐	Spitting up blood
☐	☐	☐	Spitting up phlegm
☐	☐	☐	Wheezing

Women only

I	R	S	
☐	☐	☐	Congested breasts
☐	☐	☐	Cramps or backache
☐	☐	☐	Excess menstrual flow
☐	☐	☐	Hot flashes
☐	☐	☐	Irregular cycle
☐	☐	☐	Lumps in breast
☐	☐	☐	Menopause
☐	☐	☐	Painful menstruation
☐	☐	☐	Vaginal discharge

Are you pregnant ☐ Yes ☐ No
If yes, how long _____ mo's.
Number of children _____

Check any of the following conditions you have or have had:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Chorea
- ☐ Cold sores
- ☐ Diabetes
- ☐ Diphtheria
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fever blisters
- ☐ Goiter
- ☐ Gout
- ☐ Heart disease
- ☐ Herpes
- ☐ Influenza
- ☐ Lumbago
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Venereal disease
- ☐ Whooping cough

Chiropractic Problem *(Describe)*

How long have you had this condition | Is it getting worse ☐ Yes ☐ No | Does it bother your ☐ Work ☐ Sleep ☐ Other *(specify)*

What seemed to be the initial cause

Have you seen a chiropractor before ☐ Yes ☐ No | (If yes, how long ago) | For what reason:

Are you under the care of a physician ☐ Yes ☐ No | (If yes, for what)

Have you been hospitalized in the last 5 years ☐ Yes ☐ No | For major surgery ☐ Yes ☐ No | For serious injury ☐ Yes ☐ No | Have you had any mental or emotional disorders ☐ Yes ☐ No (If yes, when)

Continued

Drugs you now take: ☐ Birth Control Pills ☐ Tranquilizers ☐ Pain killers ☐ Others *(specify)*

Do you wear: ☐ Heel lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports ☐ Negative heels ☐ Platform shoes

Age of your mattress: ☐ Comfortable ☐ Uncomfortable | Do you use a bedboard ☐ Yes ☐ No

How is most of your daytime spent? ☐ Standing ☐ Sitting ☐ Walking ☐ Other *(specify)*

Have you ever:

	Yes	No	If yes, briefly explain:
Had a broken bone?	☐	☐	
Been hospitalized?	☐	☐	
Had strains or sprains?	☐	☐	
Used a cane, crutch or other support?	☐	☐	
Been struck unconscious?	☐	☐	
Been hospitalized for other than surgery?	☐	☐	

Do you:

Take minerals, herbs or vitamins?	☐	☐
Think you need minerals, herbs or vitamins?	☐	☐
Have any drug allergy?	☐	☐

When did you last have:

	Never	0-6 mo	6-18 mo	Longer
Spinal x-ray	☐	☐	☐	☐
Spinal examination	☐	☐	☐	☐
Physical examination	☐	☐	☐	☐

Please list any other health conditions you have been treated for, or surgery you have had in the last 10 years:

Habits

	None	Light	Mod.	Heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Soft drinks	☐	☐	☐	☐
Salty foods	☐	☐	☐	☐
Water	☐	☐	☐	☐
Sugar & Products	☐	☐	☐	☐
Artificial sweeteners	☐	☐	☐	☐

Family Health Information

Some health conditions are the result of hereditary spinal weaknesses. Information about your immediate family members, brothers, sisters, parents, grandparents will give us a better understanding of your total health picture.

RELATIONSHIP	PRESENT AND PAST HEALTH PROBLEMS

Summary *(Doctor's use)*

PAIN DRAWING

Name: _____ Todays Date: _____

Examiner: _____

TELL US WHERE YOU HURT.

Please read carefully:

Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbols(s) listed below.

Ache > > > >
> > > >

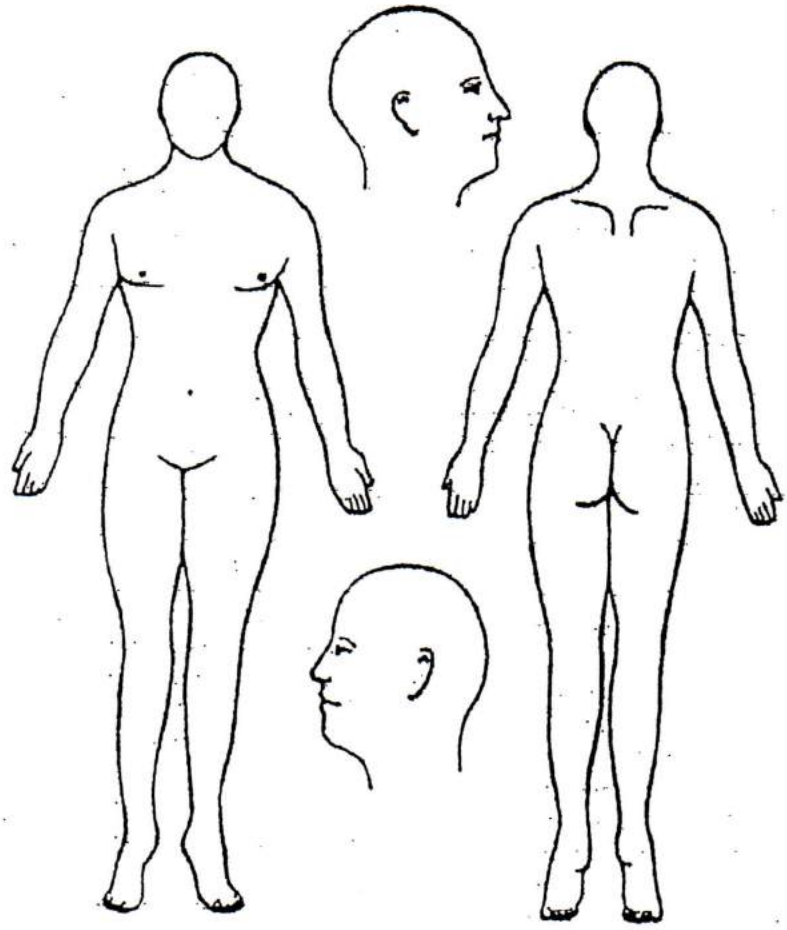
Numbness - - - -
- - - -

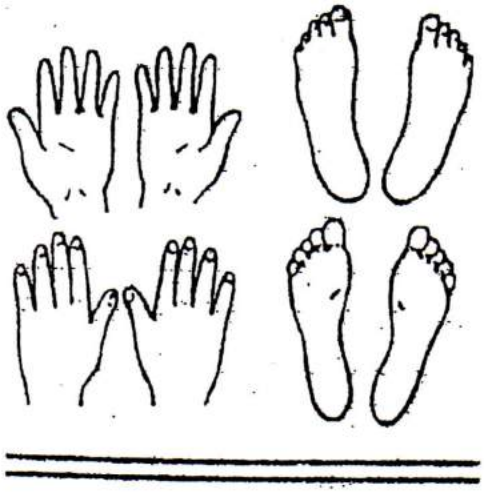
Pins and Needles o o o o
o o o o

Burning x x x x
x x x x

Stabbing / / / /
/ / / /

Throbbing ~ ~ ~ ~
~ ~ ~ ~





SEVERITY OF PAIN

List region of pain and circle severity number. [1 = least, 10 = greatest]

ex. Neck
1 2 3 (4) 5 6 7 8 9 10

1. _____
1 2 3 4 5 6 7 8 9 10
2. _____
1 2 3 4 5 6 7 8 9 10
3. _____
1 2 3 4 5 6 7 8 9 10
4. _____
1 2 3 4 5 6 7 8 9 10
5. _____
1 2 3 4 5 6 7 8 9 10

SYMPTOM SURVEY FORM

PATIENT _____ DOCTOR _____ DATE _____

INSTRUCTIONS: Number the boxes which apply to you with either a 1, 2, or 3.

(1) for MILD symptoms (occur once or twice a year)
(2) for MODERATE symptoms (occur several times a year)
(3) for SEVERE symptoms (you are aware of it almost constantly)

Leave the box BLANK if it does not apply to you!

GROUP 1

1 ☐ Acid foods upset
2 ☐ Get chilled, often
3 ☐ "Lump" in throat
4 ☐ Dry mouth-eyes-nose
5 ☐ Pulse speeds after meals
6 ☐ Keyed up—fail to calm
7 ☐ Cuts heal slowly
8 ☐ Gag easily
9 ☐ Unable to relax; startles easily
10 ☐ Extremities cold, clammy
11 ☐ Strong light irritates
12 ☐ Urine amount reduced
13 ☐ Heart pounds after retiring
14 ☐ "Nervous" stomach
15 ☐ Appetite reduced
16 ☐ Cold sweats often
17 ☐ Fever easily raised
18 ☐ Neuralgia-like pains
19 ☐ Staring, blinks little
20 ☐ Sour stomach frequent

GROUP 2

21 ☐ Joint stiffness after arising
22 ☐ Muscle-leg-toe cramps at night
23 ☐ "Butterfly" stomach, cramps
24 ☐ Eyes or nose watery
25 ☐ Eyes blink often
26 ☐ Eyelids swollen, puffy
27 ☐ Indigestion soon after meals
28 ☐ Always seems hungry; feels "lightheaded" often
29 ☐ Digestion rapid
30 ☐ Vomiting frequent
31 ☐ Hoarseness frequent
32 ☐ Breathing irregular
33 ☐ Pulse slow; feels "irregular"
34 ☐ Gagging reflex slow
35 ☐ Difficulty swallowing
36 ☐ Constipation, diarrhea alternating
37 ☐ "Slow starter"
38 ☐ Get "chilled" infrequently
39 ☐ Perspire easily
40 ☐ Circulation poor, sensitive to cold
41 ☐ Subject to colds, asthma, bronchitis

GROUP 3

42 ☐ Eat when nervous
43 ☐ Excessive appetite
44 ☐ Hungry between meals
45 ☐ Irritable before meals
46 ☐ Get "shaky" if hungry
47 ☐ Fatigue, eating relieves
48 ☐ "Lightheaded" if meals delayed
49 ☐ Heart palpitates if meals missed or delayed
50 ☐ Afternoon headaches
51 ☐ Overeating sweets upsets
52 ☐ Awaken after few hours sleep—hard to get back to sleep
53 ☐ Crave candy or coffee in afternoons
54 ☐ Moods of depression—"blues" or melancholy
55 ☐ Abnormal craving for sweets or snacks

GROUP 4

56 ☐ Hands and feet go to sleep easily, numbness
57 ☐ Sigh frequently, "air hunger"
58 ☐ Aware of "breathing heavily"
59 ☐ High altitude discomfort
60 ☐ Opens windows in closed room
61 ☐ Susceptible to colds and fevers
62 ☐ Afternoon "yawner"
63 ☐ Get "drowsy" often
64 ☐ Swollen ankles worse at night
65 ☐ Muscle cramps, worse during exercise; get "charley horses"
66 ☐ Shortness of breath on exertion
67 ☐ Dull pain in chest or radiating into left arm, worse on exertion
68 ☐ Bruise easily, "black/blue" spots
69 ☐ Tendency to anemia
70 ☐ "Nose bleeds" frequent
71 ☐ Noises in head or "ringing in ears"
72 ☐ Tension under the breastbone, or feeling of "tightness", worse on exertion

GROUP 5

73 ☐ Dizziness
74 ☐ Dry skin
75 ☐ Burning feet
76 ☐ Blurred vision
77 ☐ Itching skin and feet
78 ☐ Excessive falling hair
79 ☐ Frequent skin rashes
80 ☐ Bitter, metallic taste in mouth in mornings
81 ☐ Bowel movements painful or difficult
82 ☐ Worrier, feels insecure
83 ☐ Feeling queasy; headache over eyes
84 ☐ Greasy foods upset
85 ☐ Stools light-colored
86 ☐ Skin peels on foot soles
87 ☐ Pain between shoulder blades
88 ☐ Use laxatives
89 ☐ Stools alternate from soft to watery
90 ☐ History of gallbladder attacks or gallstones
91 ☐ Sneezing attacks
92 ☐ Dreaming, nightmare type bad dreams
93 ☐ Bad breath (halitosis)
94 ☐ Milk products cause distress
95 ☐ Sensitive to hot weather
96 ☐ Burning or itching anus
97 ☐ Crave sweets

GROUP 6

- 98 ☐ Loss of taste for meat
- 99 ☐ Lower bowel gas several hours after eating
- 100 ☐ Burning stomach sensations, eating relieves
- 101 ☐ Coated tongue
- 102 ☐ Pass large amounts of foul-smelling gas
- 103 ☐ Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.
- 104 ☐ Mucus colitis or "irritable bowel"
- 105 ☐ Gas shortly after eating
- 106 ☐ Stomach "bloating" after eating

GROUP 7

(A)

- 107 ☐ Insomnia
- 108 ☐ Nervousness
- 109 ☐ Can't gain weight
- 110 ☐ Intolerance to heat
- 111 ☐ Highly emotional
- 112 ☐ Flush easily
- 113 ☐ Night sweats
- 114 ☐ Thin, moist skin
- 115 ☐ Inward trembling
- 116 ☐ Heart palpitates
- 117 ☐ Increased appetite without weight gain
- 118 ☐ Pulse fast at rest
- 119 ☐ Eyelids and face twitch
- 120 ☐ Irritable and restless
- 121 ☐ Can't work under pressure

(B)

- 122 ☐ Increase in weight
- 123 ☐ Decrease in appetite
- 124 ☐ Fatigue easily
- 125 ☐ Ringing in ears
- 126 ☐ Sleepy during day
- 127 ☐ Sensitive to cold
- 128 ☐ Dry or scaly skin
- 129 ☐ Constipation
- 130 ☐ Mental sluggishness
- 131 ☐ Hair coarse, falls out
- 132 ☐ Headaches upon arising wear off during day
- 133 ☐ Slow pulse, below 65
- 134 ☐ Frequency of urination
- 135 ☐ Impaired hearing
- 136 ☐ Reduced initiative

GROUP 7 (continued)

(C)

- 137 ☐ Failing memory
- 138 ☐ Low blood pressure
- 139 ☐ Increased sex drive
- 140 ☐ Headaches, "splitting or rending" type
- 141 ☐ Decreased sugar tolerance

(D)

- 142 ☐ Abnormal thirst
- 143 ☐ Bloating of abdomen
- 144 ☐ Weight gain around hips or waist
- 145 ☐ Sex drive reduced or lacking
- 146 ☐ Tendency to ulcers, colitis
- 147 ☐ Increased sugar tolerance
- 148 ☐ Women: menstrual disorders
- 149 ☐ Young girls: lack of menstrual function

(E)

- 150 ☐ Dizziness
- 151 ☐ Headaches
- 152 ☐ Hot flashes
- 153 ☐ Increased blood pressure
- 154 ☐ Hair growth on face or body (female)
- 155 ☐ Sugar in urine (not diabetes)
- 156 ☐ Masculine tendencies (female)

(F)

- 157 ☐ Weakness, dizziness
- 158 ☐ Chronic fatigue
- 159 ☐ Low blood pressure
- 160 ☐ Nails weak, ridged
- 161 ☐ Tendency to hives
- 162 ☐ Arthritic tendencies
- 163 ☐ Perspiration increase
- 164 ☐ Bowel disorders
- 165 ☐ Poor circulation
- 166 ☐ Swollen ankles
- 167 ☐ Crave salt
- 168 ☐ Brown spots or bronzing of skin
- 169 ☐ Allergies—tendency to asthma
- 170 ☐ Weakness after colds, influenza
- 171 ☐ Exhaustion—muscular and nervous
- 172 ☐ Respiratory disorders

FEMALE ONLY

- 173 ☐ Very easily fatigued
- 174 ☐ Premenstrual tension
- 175 ☐ Painful menses
- 176 ☐ Depressed feelings before menstruation
- 177 ☐ Menstruation excessive and prolonged
- 178 ☐ Painful breasts
- 179 ☐ Menstruate too frequently
- 180 ☐ Vaginal discharge
- 181 ☐ Hysterectomy/ovaries removed
- 182 ☐ Menopausal hot flashes
- 183 ☐ Menses scanty or missed
- 184 ☐ Acne, worse at menses
- 185 ☐ Depression of long standing

MALE ONLY

- 186 ☐ Prostate trouble
- 187 ☐ Urination difficult or dribbling
- 188 ☐ Night urination frequent
- 189 ☐ Depression
- 190 ☐ Pain on inside of legs or heels
- 191 ☐ Feeling of incomplete bowel evacuation
- 192 ☐ Lack of energy
- 193 ☐ Migrating aches and pains
- 194 ☐ Tire too easily
- 195 ☐ Avoids activity
- 196 ☐ Leg nervousness at night
- 197 ☐ Diminished sex drive

IMPORTANT

TO THE PATIENT: Please list below the five main health complaints you have in order of their importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Informed Consent for Chiropractic Treatment

TO THE PATIENT: *You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.*

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays. The chiropractic treatment may be performed by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic working at this clinic or office. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic named below

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.

I understand that, there are some risks to chiropractic treatment including, but not limited to:

- ☐ Broken bones
- ☐ Dislocations
- ☐ Sprains/strains
- ☐ Burns or frostbite (physical therapy)
- ☐ Worsening/aggravation of spinal conditions
- ☐ increased symptoms and pain
- ☐ No improvement of symptoms or pain
- ☐ Infection (acupuncture)
- ☐ Punctured lung (acupuncture)
- ☐ Other _____

In rare cases there have been reported complications of arterial dissections n (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

TREATMENT PLAN: _____

_____

_____

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my current condition.

To be completed by the patient:

_____
print name

_____
signature of patient

_____
date signed

To be completed by the patient's representative:

_____
print name of patient

_____
print name of patient's representative

_____
signature of patient's representative

as: _____
relationship/authority of patient's representative

_____
date signed

To be completed by doctor or staff:

_____
witness to patient's signature

_____
date

_____
translated by

_____
date

Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, HSA, cash or check.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.
- **Appointments that are missed without notification or are cancelled with less than 24 hours notice will be billed at the rate of a regular office visit.**

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party _____ Date: _____

_____ Patient initials to indicate copy received.