DOUGLAS CHIROPRACTIC & MEDICAL CENTERS

DMLC 00_REV 7/8/14

CONFIDENTIAL PATIENT INFORMATION

NAME ____ SOCIAL SECURITY _____________________________

ADDRESS ____

CITY ____ STATE _____________________ ZIP _________________

AGE ________ BIRTH DATE _________________________ MARTIAL STATUE _______________ # OF CHILDREN ________

HOME PHONE _____________________________________ WORK PHONE _____________________________________

CELL PHONE ______________________________________ OCCUPATION ______________________________________

WORK ADDRESS ____

EMAIL ADDRESS ____

REFERRED BY ____

SPOUSE'S NAME _________________________________ SPOUSE'S WORK PHONE ______________________________

NEAREST RELATIVE'S PHONE _______________________________________ RELATIONSHIP _____________________

OFFICE POLICY

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT POLICIES ARE AN AGREEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. FURTHERMORE, I UNDERSTAND THAT THIS OFFICE WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTION FROM THE INSURANCE COMPANY AND THAT ANY AMOUNT AUTHORIZED PAID DIRECTLY TO THIS OFFICE WILL BE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE; AND IF PAYING BY CREDIT CARD I AUTHORIZED **DOUGLAS RAPID REHAB, P.A.** TO PUT MY BALANCE THOUGHT ACCORDINGLY. I ALSO UNDERSTAND THAT IF I SUSPEND OR TERMINATE MY CARE AND AGREE THAT 1.5% MONTHLY FINANCE CHARGES MAY BE ADDED TO MY ACCOUNT OVER 30 DAYS. IN THE CASE OF A DELINQUENT ACCOUNT, I UNDERSTAND THAT I AM RESPONSIBLE FOR ATTORNEY'S FEES AND COLLECTION FEES. I UNDERSTAND AND AUTHORIZE **DOUGLAS RAPID REHAB, P.A.** TO OBTAIN ANY PRIOR MEDICAL RECORDS OR ASSIST ME IN MY CARE AND TREATMENT IN THIS OFFICE.

PLEASE CHECK METHOD OF PAYMENT:

CASH ______________________ CHECK ______________________ CREDIT CARD ______________________

PATIENT SIGNATURE ____ DATE ___________________________