

Circle all of the conditions or symptoms you currently have, or have had in the past:

Anemia	Cancer	Head Injury	Migraine Headaches	Other: _____
Appendicitis	Chemical Dependency	Heart Disease	Osteoporosis	_____
Arthritis	Diabetes	Hepatitis	Stroke	_____
Asthma	Emphysema	Hernia	Tendonitis	_____
Blood Clots	Epilepsy	Herniated Disc	Tumors, Growths	
Breathing Difficulty	Fibromyalgia	High Blood Pressure	Ulcers	
Bursitis	Eating Disorder	HIV/AIDS	Varicose Veins	
Bronchitis	Fractures	Lymphedema	Whiplash	

Payment Policies

In fairness to our other patients and to us, 24-hour notice is required for cancellation of an appointment unless there is an emergency, or **you will be charged \$45**. We do not bill your insurance company for missed appointments or late cancellations; you are responsible. Payment is due before your next appointment.

Financial Responsibility

Once your insurance coverage has been verified, we will be glad to bill directly to and accept payment from the insurance company for covered services. Your signature below confirms that it is your responsibility to pay for all services provided. In the event that the insurance company denies payment or makes partial payment, you are responsible for the balance.

Assignment of Benefits

Your signature below authorizes and directs payment of medical benefits for services billed to the health care provider at this office.

Release of Medical Records

Your signature below authorizes the release of all your medical records on file in this office to your attorneys, health care providers, and insurance case managers, for the purpose of processing your claims, unless otherwise stated in an exclusive release of medical records signed through your attorney.

Signature: _____ Date: _____