

Today's Date: _____



ABOUT YOU

Name: _____

What you prefer to be called: _____

Birthdate: _____ Age: _____ ☐ Female ☐ Male

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Insurance Carrier: please provide card(s) _____

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

Please initial below:

_____ Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the office manager. If the account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account.

_____ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process my insurance claims.

_____ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Signature

Date

CONSENT TO TREAT A MINOR CHILD

I hereby authorize Kelley Chiropractic to administer treatment as deemed necessary, to my

- ☐ Son
- ☐ Daughter
- ☐ Dependent

Patient Name Printed

Parent or Guardian Signature

Date