Please note that we require a valid signature on all forms. You can email the forms back

First Name: _____ Last Name: _____ DOB: _____
Cellphone: _____ Email: _____ Home Phone: _____

Address: _____
_____
Referring Doctor: _____ Dr's Contact: _____

How did you hear about us? _____
EMERGENCY CONTACT First Name: _____ Last Name: _____ Cellphone: _____ Email: _____

Patient Consent Please Initial _____ Consent for Care and Treatment I, the undersigned, hereby agree and give my consent for above named practice to furnish care and treatment considered necessary and proper in treating my condition.

_____ Authorization for Signature on File and Release of Information I, the undersigned, hereby authorize the office of above named practice to affix my name to any and all claims or documents as related to any and all health benefits due me. I authorize the release of any information relating to my health care claims. A copy of this authorization shall be as valid as an original.

_____ Authorization for Assignment of Benefits I, the undersigned, hereby assign all medical benefits, to which I am entitled, to the office of above named practice, and I shall be financially responsible for any unpaid balance. In the event payment is made directly to me for services rendered by this office, I recognize the obligation to promptly remit payment to this office. I hereby authorize and instruct my insurance company to pay by check and mail directly to above named practice.

_____ Financial Responsibility I, the undersigned, understand and agree that if it becomes necessary to commence legal action, I am responsible for 30% interest if sent to collection agency and including any court costs, fees and attorney fees, in addition to my outstanding account balance. I further understand that balances over 60 days will be subject to a 1.5% finance charge, for which I am personally liable.

_____ 24 Hour Cancellation Policy Specific time is reserved for you when you schedule an appointment. If you cannot keep your scheduled appointment, please give us at least 24 hours notice so that we may reschedule your appointment and offer the reserved time to another patient.

~~There will be a charge of $125.00 for NO SHOW appointments or Office & Consent Forms 3 cancellations with less than 24-hour notification. I, the undersigned, understand that I will be personally responsible for any cancellation fees~~

_____ Appointment Reminder Message I, the undersigned, hereby authorize the office of above named practice to send reminders to my mobile number, home phone, or email address of upcoming appointments.

_____