

HANDS 2 HEALTH CHIROPRACTIC

80 Montecito Court
Sierra Madre, California 91024
626.355.2626
www.Hands2Health.com

CONFIDENTIAL PATIENT INFORMATION

Name: _____
Home Phone: _____ Cell Phone: _____
Office Phone: _____ Email: _____
Address: _____
City, State, Zip: _____
Date of Birth: _____ Gender: M F Driver's License #: _____
Occupation: _____ S.S. #: _____
Who Referred you? _____

PAYMENT AND FEE POLICIES

Payment is expected at the time of service. This office accepts Visa, MasterCard and Discover. If you are not able to pay at the time of service, please make other arrangements prior to your appointment. Postdated checks (with a reasonable time frame) are also happily accepted!

If you have insurance, you will be provided with a SuperBill to submit with your claim form. The insurance company will reimburse you. Health and accident insurance policies are an agreement between an insurance carrier and you, the patient. If any information is requested from your insurance company, assistance will be provided. There may be an additional charge depending on the amount of assistance necessary.

Returned checks will be charged a \$50.00 handling fee, in addition to the amount due.

Appointments must be cancelled at least 24 hours in advance. Last minute emergencies are understandable. If you are not able to make your appointment and do not give notice, since there are others waiting, an office visit fee of \$35.00 will be charged.

I have read the payment policies. I understand and agree that all services rendered me are my responsibility. I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. I understand that Hands 2 Health Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that there may be an additional charge for reports. I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I consent, authorize and request Hands 2 Health Chiropractic, to administer such treatment deemed advisable. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand that it is my responsibility to inform the office of any changes in my medical status.

Patient's Signature: _____ Date: _____