

Payment is expected at the time of your visit. Please indicate your preferred method of payment

CASH CHECK VISA MASTERCARD ATM

INSURANCE INFORMATION

PRIMARY

Carrier _____ Name of Insured _____

Birthday of Insured _____ Insured SSN _____

Your relationship to insured SPOUSE CHILD SELF OTHER _____

SECONDARY

Carrier _____ Name of insured _____

Birthday of Insured _____ Insured SSN _____

Your relationship to insured SPOUSE CHILD SELF OTHER _____

PLEASE PRESENT YOUR INSURANCE CARD / CERTIFICATE TO THE FRONT DESK FOR COPYING

PLEASE PRESENT YOUR DRIVERS LICENSE TO THE FRONT DESK FOR COPYING

We are happy to provide insurance billing for you as part of our service at no charge to you. However, your insurance is a contract between *you* and *your carrier*. You are ultimately responsible for all charges incurred at this office. Please sign below, acknowledging your responsibility.

SIGNATURE OF RESPONSIBLE PARTY

DATE

OUR MISSION IS TO PROVIDE

CAREFULLY CONSIDERED DIAGNOSIS

GENTLY ADMINISTERED TREATMENT

THE CARE YOU NEED, NO MORE, NO LESS

REFERRAL TO OTHER PRACTITIONERS WHEN APPROPRIATE

HONEST AND UP TO DATE RECORD KEEPING.....IN SHORT

TO TREAT YOU THE WAY WE WOULD LIKE TO BE TREATED IF WE WERE THE PATIENT.