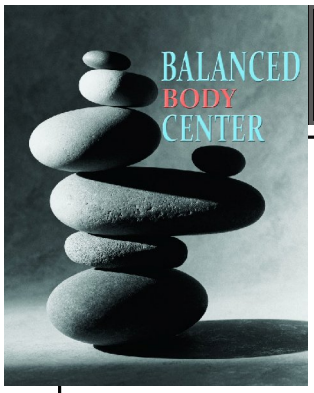

Welcome

ABOUT YOU: Today's Date: _____

Name: _____

Date of Birth _____/_____/_____

E mail : _____

Home Address: _____
Street Address City State Zip Code

Home Phone # : _____ Cell Phone # : _____

Employers Name: _____ Work Phone # : _____

Work Status: ☐ working without restrictions ☐ working with restrictions ☐ not working/off since _____

Who may we thank for referring you? _____

What type of injury are we seeing you for?

☐ Auto ☐ Other

☐ Work

☐ Sports Injury

EMERGENCY CONTACT INFORMATION:

Emergency Contact Person _____

Phone # : _____ Relationship: _____

General Consent Form: The undersigned hereby consents to evaluation and treatment rendered according to the applicable standards of care. It is understood that options exist for treatment and all treatments are choices between risks and benefits. If the risks and benefits of proposed treatment are not clear to me, I understand that further information may be requested from clinicians at Balanced Body Center. The information within this chart is confidential. I understand that all requests for release of my records must be in writing. Protected health information will be released with written authorization, with minimum disclosure necessary as related to your care. Please see Notice of Privacy Practices for more detailed information. I understand that I have a responsibility to communicate honestly with any clinician of Balanced Body Center and notify them of any changes in my health status.

Financial Awareness and Consent: I understand I am financially responsible, WHETHER OR NOT MY INSURANCE COMPANY PAYS, for all charges incurred by me. **I understand payment is due upon treatment.** I hereby assign my major medical insurance benefits, including Medicare, private insurance or other health plans and arrangements to Balanced Body Center. Any overpayment will be promptly refunded. I also authorize to release any protected health information required to secure payment.

Release of Records: I authorize Balanced Body Center to release all health records necessary for my treatment and/or evaluation.

Cancellation Policy: I agree to give 24 hour notice of cancellation and will be charged **$40.00** for services allotted if I do not show for an appointment or have a late cancellation. **Initials:** _____

Patient Signature: _____ Date: _____/_____/_____

Parent/Guardian Signature: _____ Date: _____/_____/_____