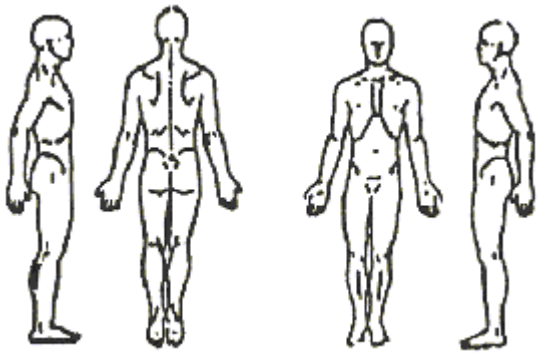
PLEASE MARK ALL PROBLEM AREAS



(FOR WOMAN PATIENTS ONLY)

DO YOU CURRENTLY USE BIRTH CONTROL? ❑ YES ❑ NO

ARE YOU PREGNANT? ❑ YES ❑ NO

ARE YOU CURRENTLY NURSING? ❑ YES ❑ NO

DO YOU HAVE CHILDREN? ❑ NO ❑ YES/HOW MANY: _____

- WE INVITE YOU TO DISCUSS WITH US ANY QUESTIONS REGARDING OUR SERVICES. THE BEST HEALTH CARE IS BASE ON FRIENDLY, MUTUAL UNDERSTANDING BETWEEN PROVIDER AND PATIENT.
- OUR POLICY REQUIRES PAYMENT IN FULL FOR ALL SERVICES RENDERED AT THE TIME OF TREATMENT, UNLESS SAID VISIT IS **FREE** OR OTHER ARRANGEMENTS HAVE BEEN MADE WITH THE OFFICE MANAGER. IF THE ACCOUNT IS NOT PAID WITHIN 90 DAYS OF THE DATE OF SERVICE AND NOT 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 INSURANCE CLAIMS.
- I UNDERSTAND THE ABOVE INFORMATION AND CERTIFY THAT THIS FORM WAS COMPLETED TO THE BEST OF MY KNOWLEDGE AND UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE OFFICE OF ANY CHANGES IN MY MEDICAL STATUS.
- I HEREBY AUTHORIZE ASSIGNMENT OF MY INSURANCE RIGHTS AND BENEFITS TO THE PROVIDER FOR SERVICES RENDERED (IF OFFERED AT THIS OFFICE)

SIGNATURE: _____ DATE: ____/____/____

(PHOTO COPY OF DRIVERS LICENSE BELOW)