



H A R P E R

WELLNESS & REHAB CENTER

Phone: (713) 622-3456 ♦ Fax: (713) 622-6408



CONFIDENTIAL PATIENT INFORMATION

Please Print

Date: _____

First Name: _____ Last Name: _____ Preferred Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: M F Marital Status: M S W D Birth Date: _____ Age: _____

Social Security #: _____ Spouse's Name: _____

Email Address: _____

Referred By: Patient (Name): _____ Physician (Name): _____

PPO (Name): _____ Lecture Health Screening Staff Other: _____

Work Status: Employed Full-Time Student Part-Time Student Other: _____

Employer: _____ Occupation: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Were you involved in an auto accident? Yes No ***If you answered yes to either question, please notify the front desk NOW.***

Were you hurt on the job? Yes No

Do you have Health Insurance? Yes No

POLICY HOLDER INFORMATION: Policy Holder Employer: _____

Name of Insured: _____ Relationship: Self Spouse Parent

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Social Security #: _____ Birth Date: _____

Name of Insurance Company: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Policy #: _____ Group #: _____

Are you covered on an additional Health Insurance Policy? Yes No

Name of Insured: _____ Relationship: Self Spouse Parent

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Social Security #: _____ Birth Date: _____

Name of Insurance Company: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Social Security #: _____ Birth Date: _____

Please list your major complaints in order of severity:

1. _____ 3. _____

2. _____ 4. _____

Patient Summary Form

PSF-750 (Rev.2/18/2009)

Instructions

Please complete this form within the specified timeline and fax to the specified fax number as indicated on Plan Summary or plan information previously provided.

*Fax number may vary by plan.

Patient Information

Patient name Last First MI			Female Male	Patient date of birth	
Patient address			City	State	Zip code
Patient insurance ID#		Health plan	Group number		
Referring physician (if applicable)		Date referral issued (if applicable)	Referral number (if applicable)		

Provider Information

Midlane Health Associates			71-0939265		
1. Name of the billing provider or facility (as it will appear on the claim form)			2. Federal tax ID(TIN) of entity in box #1		
Dana Harper, DC			<input type="checkbox"/> MD/DO <input type="checkbox"/> DC <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Both PT and OT <input type="checkbox"/> Home Care <input type="checkbox"/> ATC <input type="checkbox"/> MT <input type="checkbox"/> Other		
3. Name and credentials of the individual performing the service(s)		1104882950		713-622-3456	
4. Alternate name (if any) of entity in box #1		5. NPI of entity in box #1		6. Phone number	
4544 Post Oak Plc. Dr. Suite 287		Houston		TX 77027	
7. Address of the billing provider or facility indicated in box #1		8. City		9. State 10. Zip code	

Provider Completes This Section:

<p>Date you want THIS submission to begin:</p> <input type="text"/>	<p>Cause of Current Episode</p> <p> <input type="radio"/> 1 Traumatic <input type="radio"/> 2 Unspecified <input type="radio"/> 3 Repetitive <input type="radio"/> 4 Post-surgical <input type="radio"/> 5 Work related <input type="radio"/> 6 Motor vehicle </p>	<p>Date of Surgery</p> <input type="text"/>	<p>Diagnosis (ICD code) Please ensure all digits are entered accurately</p> <p>1° <input type="text"/></p> <p>2° <input type="text"/></p> <p>3° <input type="text"/></p> <p>4° <input type="text"/></p>
<p>Patient Type</p> <p> <input type="radio"/> 1 New to your office <input type="radio"/> 2 Est'd, new injury <input type="radio"/> 3 Est'd, new episode <input type="radio"/> 4 Est'd, continuing care </p>	<p>Type of Surgery</p> <p> <input type="radio"/> 1 ACL Reconstruction <input type="radio"/> 2 Rotator Cuff/Labral Repair <input type="radio"/> 3 Tendon Repair <input type="radio"/> 4 Spinal Fusion <input type="radio"/> 5 Joint Replacement <input type="radio"/> 6 Other </p>	<p>DC ONLY</p> <p>Anticipated CMT Level</p> <p> <input type="radio"/> 98940 <input type="radio"/> 98942 <input type="radio"/> 98941 <input type="radio"/> 98943 </p>	
<p>Nature of Condition</p> <p> <input type="radio"/> 1 Initial onset (within last 3 months) <input type="radio"/> 2 Recurrent (multiple episodes of < 3 months) <input type="radio"/> 3 Chronic (continuous duration > 3 months) </p>	<p>Current Functional Measure Score</p> <p>Neck Index <input type="text"/> DASH <input type="text"/></p> <p>Back Index <input type="text"/> LEFS <input type="text"/> (other) <input type="text"/></p>		

Patient Completes This Section:

(Please fill in selections completely) Symptoms began on:

1. Briefly describe your symptoms: _____

2. How did your symptoms start? _____

3. Average pain intensity:

Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

4. How often do you experience your symptoms?

1 Constantly (76%-100% of the time) 2 Frequently (51%-75% of the time) 3 Occasionally (26% - 50% of the time) 4 Intermittently (0%-25% of the time)

5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)

1 Not at all 2 A little bit 3 Moderately 4 Quite a bit 5 Extremely

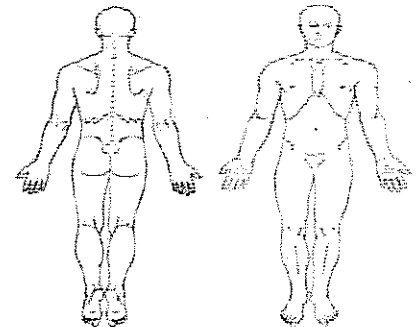
6. How is your condition changing, since care began at this facility?

0 N/A — This is the initial visit 1 Much worse 2 Worse 3 A little worse 4 No change 5 A little better 6 Better 7 Much better

7. In general, would you say your overall health right now is...

1 Excellent 2 Very good 3 Good 4 Fair 5 Poor

Indicate where you have pain or other symptoms:



Patient Signature: X

Date: _____

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____

Date _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- Ⓐ The pain comes and goes and is very mild.
- ⓐ The pain is mild and does not vary much.
- ⓑ The pain comes and goes and is moderate.
- ⓒ The pain is moderate and does not vary much.
- ⓓ The pain comes and goes and is very severe.
- ⓔ The pain is very severe and does not vary much.

Personal Care

- Ⓐ I do not have to change my way of washing or dressing in order to avoid pain.
- ⓐ I do not normally change my way of washing or dressing even though it causes some pain.
- ⓑ Washing and dressing increases the pain but I manage not to change my way of doing it.
- ⓒ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ⓓ Because of the pain I am unable to do some washing and dressing without help.
- ⓔ Because of the pain I am unable to do any washing and dressing without help.

Sleeping

- Ⓐ I get no pain in bed.
- ⓐ I get pain in bed but it does not prevent me from sleeping well.
- ⓑ Because of pain my normal sleep is reduced by less than 25%.
- ⓒ Because of pain my normal sleep is reduced by less than 50%.
- ⓓ Because of pain my normal sleep is reduced by less than 75%.
- ⓔ Pain prevents me from sleeping at all.

Lifting

- Ⓐ I can lift heavy weights without extra pain.
- ⓐ I can lift heavy weights but it causes extra pain.
- ⓑ Pain prevents me from lifting heavy weights off the floor.
- ⓒ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ⓓ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ⓔ I can only lift very light weights.

Sitting

- Ⓐ I can sit in any chair as long as I like.
- ⓐ I can only sit in my favorite chair as long as I like.
- ⓑ Pain prevents me from sitting more than 1 hour.
- ⓒ Pain prevents me from sitting more than 1/2 hour.
- ⓓ Pain prevents me from sitting more than 10 minutes.
- ⓔ I avoid sitting because it increases pain immediately.

Traveling

- Ⓐ I get no pain while traveling.
- ⓐ I get some pain while traveling but none of my usual forms of travel make it worse.
- ⓑ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- ⓒ I get extra pain while traveling which causes me to seek alternate forms of travel.
- ⓓ Pain restricts all forms of travel except that done while lying down.
- ⓔ Pain restricts all forms of travel.

Standing

- Ⓐ I can stand as long as I want without pain.
- ⓐ I have some pain while standing but it does not increase with time.
- ⓑ I cannot stand for longer than 1 hour without increasing pain.
- ⓒ I cannot stand for longer than 1/2 hour without increasing pain.
- ⓓ I cannot stand for longer than 10 minutes without increasing pain.
- ⓔ I avoid standing because it increases pain immediately.

Social Life

- Ⓐ My social life is normal and gives me no extra pain.
- ⓐ My social life is normal but increases the degree of pain.
- ⓑ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- ⓒ Pain has restricted my social life and I do not go out very often.
- ⓓ Pain has restricted my social life to my home.
- ⓔ I have hardly any social life because of the pain.

Walking

- Ⓐ I have no pain while walking.
- ⓐ I have some pain while walking but it doesn't increase with distance.
- ⓑ I cannot walk more than 1 mile without increasing pain.
- ⓒ I cannot walk more than 1/2 mile without increasing pain.
- ⓓ I cannot walk more than 1/4 mile without increasing pain.
- ⓔ I cannot walk at all without increasing pain.

Changing degree of pain

- Ⓐ My pain is rapidly getting better.
- ⓐ My pain fluctuates but overall is definitely getting better.
- ⓑ My pain seems to be getting better but improvement is slow.
- ⓒ My pain is neither getting better or worse.
- ⓓ My pain is gradually worsening.
- ⓔ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back
Index
Score

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____

Date _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- Ⓐ I have no pain at the moment.
- ① The pain is very mild at the moment.
- ② The pain comes and goes and is moderate.
- ③ The pain is fairly severe at the moment.
- ④ The pain is very severe at the moment.
- ⑤ The pain is the worst imaginable at the moment.

Personal Care

- Ⓐ I can look after myself normally without causing extra pain.
- ① I can look after myself normally but it causes extra pain.
- ② It is painful to look after myself and I am slow and careful.
- ③ I need some help but I manage most of my personal care.
- ④ I need help every day in most aspects of self care.
- ⑤ I do not get dressed, I wash with difficulty and stay in bed.

Sleeping

- Ⓐ I have no trouble sleeping.
- ① My sleep is slightly disturbed (less than 1 hour sleepless).
- ② My sleep is mildly disturbed (1-2 hours sleepless).
- ③ My sleep is moderately disturbed (2-3 hours sleepless).
- ④ My sleep is greatly disturbed (3-5 hours sleepless).
- ⑤ My sleep is completely disturbed (5-7 hours sleepless).

Lifting

- Ⓐ I can lift heavy weights without extra pain.
- ① I can lift heavy weights but it causes extra pain.
- ② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ④ I can only lift very light weights.
- ⑤ I cannot lift or carry anything at all.

Reading

- Ⓐ I can read as much as I want with no neck pain.
- ① I can read as much as I want with slight neck pain.
- ② I can read as much as I want with moderate neck pain.
- ③ I cannot read as much as I want because of moderate neck pain.
- ④ I can hardly read at all because of severe neck pain.
- ⑤ I cannot read at all because of neck pain.

Driving

- Ⓐ I can drive my car without any neck pain.
- ① I can drive my car as long as I want with slight neck pain.
- ② I can drive my car as long as I want with moderate neck pain.
- ③ I cannot drive my car as long as I want because of moderate neck pain.
- ④ I can hardly drive at all because of severe neck pain.
- ⑤ I cannot drive my car at all because of neck pain.

Concentration

- Ⓐ I can concentrate fully when I want with no difficulty.
- ① I can concentrate fully when I want with slight difficulty.
- ② I have a fair degree of difficulty concentrating when I want.
- ③ I have a lot of difficulty concentrating when I want.
- ④ I have a great deal of difficulty concentrating when I want.
- ⑤ I cannot concentrate at all.

Recreation

- Ⓐ I am able to engage in all my recreation activities without neck pain.
- ① I am able to engage in all my usual recreation activities with some neck pain.
- ② I am able to engage in most but not all my usual recreation activities because of neck pain.
- ③ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ④ I can hardly do any recreation activities because of neck pain.
- ⑤ I cannot do any recreation activities at all.

Work

- Ⓐ I can do as much work as I want.
- ① I can only do my usual work but no more.
- ② I can only do most of my usual work but no more.
- ③ I cannot do my usual work.
- ④ I can hardly do any work at all.
- ⑤ I cannot do any work at all.

Headaches

- Ⓐ I have no headaches at all.
- ① I have slight headaches which come infrequently.
- ② I have moderate headaches which come infrequently.
- ③ I have moderate headaches which come frequently.
- ④ I have severe headaches which come frequently.
- ⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck
Index
Score

Please list any medications you currently take? Nerve Pills Pain Killers Muscle Relaxers "Pep" Pills Tranquilizers
 Birth Control Pills Other (please specify):

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall diagnosis, treatment plan and possibility of being accepted for care. Please check the appropriate box if you have been diagnosed with the following:

- | | | |
|--|--|---|
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Measles | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Mumps | <input type="checkbox"/> Venereal Disease/Infection |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Typhoid Fever | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental Disorder |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Cancer | <input type="checkbox"/> Lumbago |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Goiter | |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Influenza | |

Please check any conditions you are currently diagnosed with or have been diagnosed with in the past:

MUSCULO-SKELETAL

- Low Back Pain
- Pain between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficulty chewing/ Clicking jaw

- Headaches/Migraines
- HIV Positive

GASTRO-INTESTINAL

- Poor or Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Problems
- Abdominal Cramps
- Gas or Bloating after meals
- Heartburn
- Black/Bloody Stool
- Colitis

C-V-R

- Chest Pain
- Shortness of Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling

NERVOUS SYSTEM

- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion
- Depression
- Fainting
- Convulsions
- Cold/Tingling in Extremities
- Changes in Handwriting
- Irritability
- Changes in Personality

EENT

- Vision Problems
- Dental Problems
- Sore Throat
- Earaches
- Hearing Difficulty/Impairment
- Stuffed Nose

GENERAL

- Allergies
- Loss of Sleep
- Fever

GENITO-URINARY

- Bladder Problems
- Painful/Excessive Urination
- Discolored Urine

MALE / FEMALE CODE

- Menstrual Irregularity
- Menstrual Cramping
- Vaginal Pain
- Vaginal Infections
- Breast Pain / Lumps
- Prostate Problems / Sexual Dysfunction
- Genital Herpes
- Menopause

Would you like us to send a report of your findings to your physician? YES NO If Yes, please complete the information listed below:

Physician Name: _____ Practice Name: _____
 Address: _____ City/State/Zip: _____
 Phone: _____

THE PURPOSE OF OUR CLINIC IS TO SUPPORT EACH INDIVIDUAL IN ACHIEVING THEIR OPTIMUM HEALTH AND TO EDUCATE THEM SO THAT THEY MAY UNDERSTAND A MULTIDISCIPLINED APPROACH TO HEALTH AND IN TURN, EDUCATE OTHERS.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due.

Patient Signature: _____ Date: _____

Guardian or Spouse's Signature Authorizing Care: _____ Date: _____

IN CASE OF EMERGENCY: (Name of relative or close friend not living in your home)

Name: _____
 Address: _____ Phone: _____

NOTICE OF PRIVACY PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and the methods you can use to request access to this information. Please review this notice carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, personal research and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent. You may request restrictions on disclosure on this information. By law, we are not required to grant your request. However, if we decide to grant your request, we are bound by our agreement.

RELEASE OF INFORMATION:

By signing this form, you are granting consent to Harper Wellness & Rehab to use and disclose your protected health information for the purposes of treatment, payment and healthcare operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office at (713) 622-3456. You have a right to request a restriction on how we use and disclose your private health information for the purposes of treatment, payment or health care operations. By law, we are not required to grant your request. However, if we decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent that we have already used or disclosed your protected health information in reliance on your consent.

MEDICARE AND MEDICAID CONSENT TO RELEASE INFORMATION:

I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers any information needed for this or any other related Medicare or Medicaid claim.

- ✓ Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.
- ✓ You may inspect and receive copies of you records within 30 days of your request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation of your medical records.
- ✓ You may request changes to your records. Our practice has the right to accept or deny your request.
- ✓ We maintain a history of protected health information disclosures that is accessible to you.
- ✓ In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.
- ✓ Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.
- ✓ For your convenience, you may obtain an Authorization for Release of Records form on our website at www.harperwellness.com or by calling (713) 622-3456.
- ✓ You may file a complaint about privacy violations by contacting our Office Manager at (713) 622-3456.

X _____

PATIENT SIGNATURE

The effective date of this Notice of Privacy Practices is (today's date): _____

PATIENT CONSENT

CONSENT FOR TREATMENT:

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

VERIFICATION OF NON-PREGNANCY (Female Patients Only):

By my signature on this form I do hereby state that to the best of my knowledge I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period: _____

PRINT PATIENT NAME

X _____

PATIENT SIGNATURE

IF YOU ARE NOT THE PATIENT, PRINT YOUR NAME AND STATE YOUR RELATIONSHIP TO PATIENT

OFFICE FINANCIAL POLICY

Our policy is to extend you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expenses and allows you to place your family under our care.

1. **If You Do Not Have Insurance:** All payments are due at the time of service or by an authorized payment plan. For bookkeeping purposes, we suggest that you prepay for your scheduled appointments with the doctor. This will greatly reduce your time at the front desk and help us minimize our bookkeeping expenses.
 - √ \$5 Billing Fee – All self-payments are due at the time of service. Self-payments NOT paid at the time service will have a \$5.00 billing fee added to your charges to cover our expenses for processing and mailing patient statements. We regret the imposition of this additional charge, but it is necessary to cover our increased costs of business, as we no longer employ a billing service. You may avoid this additional charge by paying your self-payment at the time of service. For your convenience, you may also set up an authorized payment plan or retain a credit card number on file with us to cover your portion of services rendered.
2. **If You Have Insurance:** All deductibles and co-payments are due at the time of service or through an authorized payment plan. For bookkeeping purposes, we suggest that you prepay for your scheduled appointments with the doctor. This will greatly reduce your time at the front desk and help us minimize our bookkeeping expenses.
 - √ You are considered a self-pay patient until you give us your insurance information and we qualify and accept your insurance coverage. We do not accept assignment for secondary insurance carriers, but we will be happy to provide you with a claim for your secondary carrier.
 - √ Our fees are considered usual, customary and reasonable by most insurance companies and are therefore covered up to the maximum allowance determined by each carrier. This statement does not apply to insurance companies that reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.
 - √ If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active role in the recovery of your claim. If your carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.
 - √ When your treatment plan is once per month or less in frequency, your insurance carrier may deem your treatment as maintenance and not cover the visit. Charges for services rendered will be due as they are performed or by an authorized payment plan. We will happily provide you with an insurance claim form for these visits.
 - √ If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claims already submitted.
 - √ \$5 Billing Fee – In keeping with your insurance contract, all patient co-pays and/or co-insurances are due at the time of service. All patient co-pays and/or co-insurance NOT paid at the time of service will have a \$5.00 billing fee added to your charges to cover our expenses for processing and mailing patient statements. We regret the imposition of this additional charge, but it is necessary to cover our increased costs of business, as we no longer employ a billing service. You may avoid this additional charge by paying your co-pays and/or co-insurance at the time of service. For your convenience, you may also set up an authorized payment plan or retain a credit card number on file with us to cover your portion of services rendered.

Patient's Printed Name: _____

Signature: X _____ Date: _____

Finance Counselor: _____ Date: _____

Front Desk: _____ Date: _____

For your convenience, you may retain your credit card number on file with us.

Credit Card #: _____ Exp Date: _____

Your name as it appears on the card: _____