# CENTERED IN MOTION

Chiropractic & Movement Rehabilitation

**PATIENT INFORMATION**

Today's Date

Name Dr. Ms. Mr. Nickname

Birth Date Gender

Address

City State Zip

Primary Phone ( ) Other Phone ( )

Email

Person to Contact in Case of Emergency Phone ( )

Spouse or Parent's Name Phone ( )

Patient's Employer or School Phone ( )

Whom May We Thank for Referring You?

**RESPONSIBLE PARTY (please fill out if different than patient)**

Responsible for this Account

Relation to Patient □ Spouse □ Parent □ Other:

Birth Date SSN

Address Home Phone ( )

Employer Work Phone ( )

**ACKNOWLEDGEMENT AND UNDERSTANDING**

**Please read and initial each item below.**

1. _____ **I hereby authorize Centered in Motion to provide chiropractic services for me.**
2. _____ **I understand and agree that regardless of insurance coverage, I am liable for any charges incurred as a result of services rendered to me at Centered in Motion.**
3. _____ **I authorize release of patient's records to third parties requiring these records for determination of financial liability.**
4. _____ **I understand that there is a fee of $30.00 if I don't give at least *24 hour notice by phone* when canceling any appointments.**

**AUTHORIZATION AND RELEASE**

I authorize and request my insurance company to pay directly to the chiropractor or chiropractic clinic insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize use of this signature on all insurance submissions.

Patient/ Guarantor Signature _____ Date_____

**Please fill out below if the patient is a minor.**

**CONSENT TO TREAT A MINOR**

As a parent or legal guardian I hereby authorize treatment for
*patient's full name*_____ *patient's birth date*_____
to any chiropractic treatment deemed advisable, if a parent or legal guardian is not available when the child is brought in for treatment.
This authorization will be effective until the patient is of age to consent to treatment, unless noted otherwise here: _____

Parent or Guardian's Signature _____ Date_____
Witnessed by _____