

Pat Dougherty, D.C.
Chiropractic Lifecenter, Inc. @ North Central Chiropractic
2110 N. Washington, Spokane WA 99205
509 327 4373, (fax) 509 327 1244

PATIENT INFORMATION: PLEASE PRINT

DATE _____

NAME _____ e:mail _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ BIRTH DATE _____ SEX (M) ____ (F) _____

MARITAL STATUS _____ SPOUSES NAME _____

IN CASE OF EMERGENCY WHO SHOULD BE NOTIFIED _____

RELATIONSHIP _____ PHONE NUMBER _____

EMPLOYER _____ **WORK PHONE** _____ **X** _____

HOW DID YOU LEARN OF OUR PRACTICE? _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PATIENT FINANCIAL INFORMATION: (HOW YOU CHOOSE TO PAY FOR YOUR SERVICES)

() **HEALTH INSURANCE**; NAME OF INSURANCE _____

() **AUTO INSURANCE**; NAME OF INSURANCE _____

NAME OF INSURED _____

If you have retained an attorney, what is their name? _____

ASSIGNMENT AND RELEASE (**FOR INSURANCE PATIENTS ONLY**): I THE UNDERSIGNED ASSIGN DIRECTLY TO CHIROPRACTIC LIFECENTER, INC, AND DR. PAT DOUGHERTY ALL MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. SHOULD MY INSURANCE COMPANY SEND ME A CHECK/DRAFT FOR SERVICES RENDERED ME), I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO IMMEDIATELY GIVE IT TO YOU. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE BENEFITS PAYMENT. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL OF MY INSURANCE SUBMISSIONS.

SIGNATURE _____ DATE _____

() **CASH**: () PAYMENT AT THE TIME OF SERVICE () I NEED TO DISCUSS PAYMENT

IS YOUR CONDITION EMPLOYMENT RELATED? _____ ; RELATED TO AN ACCIDENT? _____ ;
IF SO, WHAT STATE; _____

AUTHORIZATION TO TREAT A MINOR:

I HEREBY GIVE MY PERMISSION TO THE DOCTORS AT THIS CLINIC TO RENDER CHIROPRACTIC TREATMENT TO MY SON () DAUGHTER ()

PARENT/GUARDIAN'S SIGNATURE _____ DATE _____

THE ABOVE INFORMATION IS ACCURATE

SIGNED _____ DATE _____