Robert Curtis D.C. P.S. dba Advanced Sports Chiropractic

Confidential Patient Information

Name ____ Date ______________

Home Phone _________________________ Work Phone ________________________

Cell Phone _______________________ Social Security # _________________________

Address ____

City ________________________________ State __________ Zip ________________

e-mail ____

Occupation _____________________________ Employer _______________________

Sex M F Date of Birth _____________ Age _____ single married separated divorced

Spouse / Significant other ____

Who is responsible for this account? _____________________________________

In case of emergency, whom should we notify? ________________ Phone______________

Whom may we thank for referring you to us? _____________________________________

Cash Financial Policy

Many insurance companies do not cover ancillary procedures such as:

- 97110 – Therapeutic Exercises (stretching, core strengthening, tubing, etc.)
- 97140 – Manual Therapies (Graston Technique, etc.)
- 97124 – Massage Therapies (effleurage, compression, tapotement)

By signing below, you agree to pay Robert E. Curtis, D.C., P.S. for one or more of these services that are outside of your insurance plan, if your plan allows. A time of service discount will be applied to the charges incurred, and shall be paid for at the time of service. Special considerations for payment plans are on a case by case basis.

Signature ____ Date______________

Insurance Financial Policy

I understand that insurance policies are an arrangement between an insurance carrier and myself. Payment is expected at the time the services are rendered unless arrangement are made in advance, I authorize payment of medical benefits to Robert E. Curtis D.C., P.S. , and my signature will act as authorization. I understand that this office will prepare any necessary insurance reports and forms on my behalf, but Robert E. Curtis D.C., P.S. cannot be held responsible for lack of payment by my insurance company. I am ultimately responsible for any amount not paid by my insurance company. If I suspend or terminate my care, any fees for professional services rendered to me will be immediately due and payable.

****As of January 1, 2007 there will be a $30.00 fee for no-show appointments. Please allow 24 hours notice If you are unable to make your appointment.****

By my signature below I certify that I have read and understand the above financial policies.

Signature ____ Date______________