FIT WELLNESS CENTER INTAKE FORM

(Please give this form to Front Desk as soon as complete)

Patient Personal/Confidential Data

Email: _____ Date _____

Full Name _____ Date of Birth_____

Address _____City_____ State_____ Zip_____

SS# _____ Home Phone_____ Cell Phone _____

Spouse Name _____ # of Children _____

Parents Name (if under 18) _____

Occupation: _____ Employer: _____ Business Ph: _____

Business Address: _____ City _____ State_____Zip _____

Whom may we thank for referring you at our office? _____

FINANCIAL/INSURANCE INFORMATION

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that FIT Wellness Center 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 FIT Wellness Center, will be credited to my account upon receipt. However, 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 are immediately due and payable. Any account that has an unpaid balance due over 30 days will be charged interest at the rate of 21% per year.

Payment in full is expected at the time of service unless other arrangements have been made & agreed upon in writing.

Method of Payment: □ Cash/Check/Credit □ Health Insurance □ Auto Insurance □ Medicare □Work Comp Insurance Co: _____

CONSENT OF PROFESSIONAL SERVICES & RELEASE OF INFORMATION

I hereby authorize and release the doctor and whomever he/she may designate as his/her assistants to administer treatment, physical examination, x-ray studies laboratory procedures, chiropractic care, acupuncture, massage therapy or any clinic services that he/she deems necessary in my case: and I further authorize him/her to disclose all or any part of my patient's record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

Patient Signature: _____Parent/Guardian Signature _____