Watkins Total Healthcare

961 Green Street, NE * Gainesville, GA 30501

Phone: 770-534-0656 * Fax: 770-534-9553

PATIENT INFORMATION

Patient Name: _____
Last First Middle

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Cell Phone: _____ Cell Phone Carrier: _____

May we leave a voicemail/message? YES NO

Email Adress: _____

Sex: MALE FEMALE Date of Birth: _____

Social Security Number: _____

Employer: _____ Occupation: _____

May we call you at work? YES NO Work number: _____

Marital Status: Minor Single Married Divorced Widowed Separated Other

SPOUSE'S INFORMATION

Spouse's Name: _____

Spouse's Employer: _____

May we speak with your spouse conserning your care? YES NO

Who referred you to our practice?

EMERGENCY CONTACT

Name: _____ Relation: _____

Phone: (Home) _____ (Cell) _____

Nearest Relative not living with you: _____ Phone Number: _____

Nearest Friend not living with you: _____ Phone Number: _____

May we contact either of these in case of an emergency? YES NO

ACCIDENT INFORMATION

Are your injuries related to an accident? YES NO

Type of accident? AUTO WORK OTHER

Date of injury/accident: _____

Has it been reported? YES NO

Whom was it reported to?

Has an Attorney been assigned to your case? YES NO

Attorney's Information: _____

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RESPONSIBLE PARTY INFORMATION

Responsible Party Name: _____

Last First Middle

Address (if different from above): _____

Phone: (Home) (Cell) (Work)

Responsible Party's Employer: _____

INSURANCE INFORMATION

Do you have health insurance? YES NO

Name of Carrier: _____

Name of Policy Holder: SS#:

Relationship to patient: DOB: Phone:

ID # Group #

Member service phone number: _____

Do you have a secondary insurance? YES NO

Name of Carrier: _____

Name of Policy Holder: SS#:

Relationship to patient: DOB: Phone:

ID # Group #

Member service phone number: _____

Are you covered under any other health care plan?	YES	NO
Are you covered under an employer or union policy?	YES	NO
Have you ever served in the military?	YES	NO
Have you made any changes to your choice of Medicare options in the last open enrollment period?	YES	NO

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Patient Name: _____ Date of Birth:_____

Primary Care Physician: _____ Phone #: _____
Are you currently under drug and/or medical care? YES NO Explain: _____
Date of last Physical exam: _____ Last labs: _____
Do you see a specialist : (May we have their name and specialty?)

_____

_____

Allergies: (list all allergies, types of reaction, and year of reaction)

_____

_____

_____

Medications: (list all medications you currently take, include vitamins, herbal supplements, and any over the counter medicines)

Name of Medication	Dose	Frequency Taken	Diagnosis/Reason

Surgeries/Hospitalizations: (please list all)

Year	Surgery	Overnight stay at hospital	Name of Hospital

Please complete the following items that apply to you:

Caffine per day: (this includes coffee, teas, and soda) None 1-3 cups 3-6 cups 6+ cups
Tobacco Use: Never Former smoker current smoker _____packs/day
Alcohol: NONE Casual Moderate Heavy Beer Wine
Drug use: YES NO
Exercise: NONE Daily Weekly Walks Runs Swims
Does your work activities mostly involve: Sitting Standing Light Labor Heavy Labor
Do you sleep on your: Back Side Stomach
Do you use a cervical pillow? YES NO
Which is your dominate hand? Right Left

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Patient Name: _____ **Date of Birth:**_____

Please indicate if you are currently experiencing any of the following conditions:

__Neck Pain/Stiffness	__Pins/Needles in Arm	__Light Bothers Eyes	__Sudden Weight Loss	__Nausea
__Back Pain/Stiffness	__Pins/Needles in Legs	__Depression	__Loss of Taste	__Cold Feet
__Arm/Hand Pain	__Fatigue	__Nervousness	__Loss of Memory	__Chest Pain
__Leg/Knee Pain	__Sleeping Difficulties	__Tension	__Jaw Problems	__Fever
__Headaches	__Loss of Smell	__Cold Sweats	__Constipation	__Fainting
__Dizziness	__Allergies	__Stomach Problems	__Shortness of Breath	
__Asthma	__Blurred Vision	__Night Pain	__Bowel/Bladder Changes	

Please indicate if you have ever had any of the following:

__Aids/HIV	__Cataracts	__Hernia	__Pacemaker	__Suicide Attempts
__Alcoholism	__Chemical Dependency	__Herniated Disc	__Parkinson's Disease	__Thyroid Problems
__Allergy Shots	__Chicken Pox	__Herpes	__Pinched Nerve	__Tonsillitis
__Anemia	__Diabetes	__High Cholesterol	__Pneumonia	__Tuberculosis
__Anorexia	__Emphysema	__Kidney Disease	__Polio	__Tumors/Growths
__Appendicitis	__Epilepsy	__Liver Disease	__Prostate Problems	__Typhoid Fever
__Arthritis	__Fractures	__Measles	__Prosthesis	__Ulcers
__Asthma	__Glaucoma	__Migraines	__Psychiatric Care	__Vaginal Infections
__Bleeding Disorder	__Goiter	__Miscarriage	__Rheumatoid Arthritis	__Venereal Disease
__Breast Lump	__Gonorrhea	__Mononucleosis	__Rheumatic Fever	__Whooping Cough
__Bronchitis	__Gout	__Multiple Sclerosis	__Scarlet Fever	
__Bulimia	__Heart Disease	__Mumps	__Stroke	
__Cancer	__Hepatitis	__Osteoporosis	__Other_____	

Briefly describe any medical illness you are being treated for:

_____

_____

_____

_____

_____

Family History:

Is there a family history of the following conditions? (Indicate parent, grandparent, or sibling)

Cancer _____ Hypertension _____

Diabetes _____ Kidney Disease _____

Heart Disease _____ Stroke _____

Current Symptom(s)

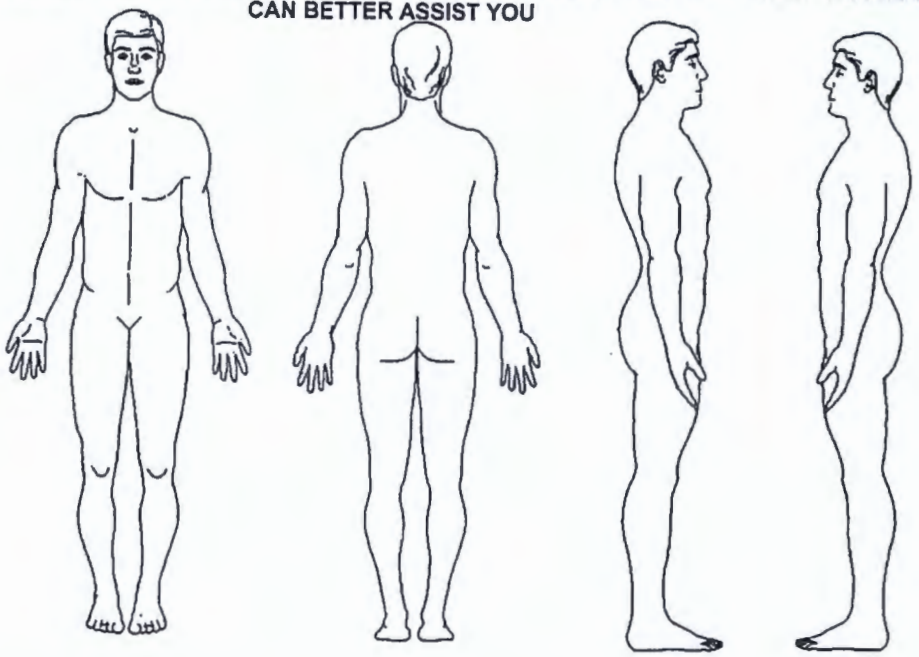
NAME: _____ Chart #: _____

Reason for visit _____

_____

*** PLEASE USE THE LETTER (S) BELOW TO MARK THE DRAWING(S) WITH THE LOCATION AND TYPE OF SENSATIONS YOU ARE EXPERIENCING. PLEASE MARK ALL SYMPTOMS THOUROUGHLY SO WE CAN BETTER ASSIST YOU**

KEY:
P = Pain
D = Dull
N = Numb
B = Burning
T = Tingling
SH= Shooting
TH= Throbbing
O = Other
M = Muscle Spasm



* PLEASE INDICATE THE SEVERITY OF YOUR CONDITION ON A SCALE OF **0-10**

(0 being no pain, 10 being the worst possible pain) 1._____ currently 2._____ at it's worst

When did you first notice the symptoms? _____

Did anything cause the pain/symptoms? _____

Is the pain: ☐ Constant OR ☐ intermittent (Come and Go)

Is it getting progressively worse? ☐ No ☐ Yes

Type of Pain? ☐ Tight ☐ Stiff ☐ Ache ☐ Sharp ☐ Shooting
☐ Throbbing ☐ Burning ☐ Dull ☐ Numb ☐ Tingling ☐ Other

Does anything make it worse? _____

Does anything make it better? _____

Does it radiate? ☐ No ☐ Yes ☐ Right Arm ☐ Left Arm ☐ Right Leg ☐ Left Leg

Do you experience the pain at a particular time of day? _____

Do you experience night pain? ☐ No ☐ Yes, explain _____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreational Activities

What activities do you enjoy, but do poorly, or not all because of the pain? _____

Painful movements: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

What have you done to treat the pain before today? _____

PATIENT SIGNATURE (X) _____ DATE _____

PARENT/GUARDIAN SIGNATURE (X) _____ DATE _____

NEUROLOGICAL AND VASCULAR PATIENT QUESTIONNAIRE

NAME _____ **DATE** _____

For any YES answer, please notify the Doctor:

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? NO YES
   Comment: _____
2. Do you have weakness, numbness or burning in your shoulder, arms or hands? NO YES
   Comment: _____
3. Do your hands or arms fall asleep regularly? NO YES
   Comment: _____
4. Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES
   Comment: _____
5. Do you suffer from a loss of handgrip strength? NO YES
   Comment: _____
6. Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES
   Comment: _____
7. Do you have weakness, numbness or burning in your buttocks, legs or feet? NO YES
   Comment: _____
8. Do your legs or feet fall asleep regularly? NO YES
   Comment: _____
9. Do you have reduced feeling (sensation) or swelling in your legs, feet? NO YES
   Comment: _____
10. Do you suffer from cold hands or feet? NO YES
    Comment: _____
11. Do you suffer from headaches, dizziness or memory loss? NO YES
    Comment: _____
12. Do you have difficulty maintaining your balance? NO YES
    Comment: _____
13. Do you suffer from vertigo or blurred vision? NO YES
    Comment: _____
14. Do you suffer from a reduced hearing capacity? NO YES
    Comment: _____
15. Do you suffer from ringing in your ears? NO YES
    Comment: _____
16. Do you have bladder or bowel control problems on a regular basis? NO YES
    Comment: _____

Neck Index

Form N1-100

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

⓪ 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.

Sleeping

⓪ 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).

Reading

⓪ 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.

Concentration

⓪ 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.

Work

⓪ 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.

Personal Care

⓪ 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.

Lifting

⓪ 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.

Driving

⓪ 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.

Recreation

⓪ 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.

Headaches

⓪ 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 _____

Back Index

Form BI100

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

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ 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.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ 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 _____

WATKINS TOTAL HEALTHCARE
961 Green Street,
Gainesville GA 30501
770-534-0656

Patient Name: _____

Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Watkins Total Healthcare or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy. _____Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Therapy and Rehab areas are open areas. Multiple individuals receive treatment at the same time. This is meant to be a quite area for you to relax and enjoy your therapy. In the event you need to discuss private medical/treatment issues, a private room will be provided for you.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information. I also acknowledge that I have received the Notice of Privacy Practices and Patient Rights.

_____ _____
Patient or Legally Authorized Individual Signature Date

_____ _____
Witness Signature Date

Patient name: _____

Watkins Total Health Care

961 Green Street NE * Gainesville, GA 30501

ASSIGNMENT OF BENEFITS

I, _____, understand that services rendered to me by Watkins Total Healthcare are my financial responsibility and that the provider will bill my insurance company as a courtesy. I authorize my insurance company to pay my benefits directly to Watkins Total Healthcare and I understand that I will be fully responsible for any outstanding balances on my account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional services over and above this insurance payment.

I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by my insurance company.

I authorize the provider to release any information necessary to adjudicate the claim and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance company send payment to me, I will forward the payment to Watkins Total Healthcare within 48 hours. I agree that if I fail to send the payment to the Provider and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies. In the event patient receives any check, draft or other payment subject to this agreement, I will immediately deliver said check draft, or payment to provider. Any violations of this agreement will, at provider's election, terminate patient charge privileges with provider and bring any balance owed by patient to provider immediately due and payable.

To avoid this additional cost and inconvenience, should the insurance company forward payment to me, I authorize Watkins Total Healthcare to facilitate payment utilizing the credit card number on file to resolve the balance. A photocopy of this Assignment shall be considered as effective and valid as the original.

I authorize the provider to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

_____ _____

Signature of policyholder Date

_____ _____

Patient or Parent/Guardian Signature Date

_____ _____

Witness Date

There is no higher privilege than you as a patient making referrals of a family member or friend to this office.
We welcome your referrals and look forward to a doctor/patient relationship with you.

Patient Name: _____

Watkins Total Health Care

961 Green Street NE * Gainesville, GA 30501

FINANCIAL POLICY

For Insurance Patients

We are committed to providing you with the best possible medical care. If you have a special financial need, we are willing to work with you. The following information is provided to avoid any misunderstandings or disagreements concerning payment for professional services. We will file your insurance as a courtesy to you, however, YOU ARE ULTIMATELY RESPONSIBLE FOR YOUR BILL.

1. Our office will be happy to submit to most insurance carriers. We participate with a variety of insurance plans including Medicare. It is your responsibility to:
    - Provide the office with any updated insurance information.
    - Pay your co-pay and/or any deductibles at each visit. Payment can be made by cash, check or credit card. We accept Visa, Master Card, Discover, and Care credit.
    - Pay in full for any services that are not covered by your insurance plan.
    - Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations, this is your responsibility.
2. If you have insurance that we do not participate in, our office is happy to file the claim upon request, however, payment in full is expected at the time of service.
3. Financially you will be responsible for all charges whether or not paid by my insurance provider.
4. If the patient is a minor (18 years and not emancipated), the parent or guardian must sign below. The parent or guardian who presents with the minor is responsible for any payment due at the time of service or any remaining balance after insurance pays.
5. If you have any questions about your insurance, we are happy to help you. However, specific coverage issues should be directed to your insurance company member services department. The phone number should be located on your insurance card.
6. It is our policy not to exceed more than $150.00. We reserve the right to terminate professional care if your co-insurance balance exceeds the $150.00. Watkins Total Healthcare offers multiple payment plans, please speak with one of our team members for more information.
7. Returned checks must be paid by cash, money order, cashier's check or credit card. The fee for a returned check is $15.00 per check and payment with a check will no longer be accepted.
8. All massages are subject to a 24 hour cancellation notice. Outside of a 24 hour notice there will be no charge for cancellation, however, inside the 24 hour notice you will be responsible for the full charge for the service.

I have read and understand the above stated financial policy. I accept responsibility for services as outlined above. I authorize the release of medical and/or any other information to my insurance company, to the Social Security Administration, Health Care Financing Administration and/or its intermediaries. I permit a copy of this authorization to be used in place of an original on all insurance claims, including electric submissions. I request payments of any medical /chiropractic benefits from my insurance company to be sent directly to **Watkins Total Healthcare.** I understand that I am financially responsible for all charges incurred in care and treatment. This authorization may be revoked by either me or my insurance company at any time in writing.

_____ _____

Patient or Parent/Guardian Signature Date

There is no higher privilege than you as a patient making referrals of a family member or friend to this office. We welcome your referrals and look forward to a doctor/patient relationship with you.

Patient Name: _____

Watkins Total Health Care

961 Green Street NE * Gainesville, GA 30501

FINANCIAL POLICY

For NON Insurance Patients

We are committed to providing you with the best possible medical care. If you have a special financial need, we are willing to work with you. The following information is provided to avoid any misunderstandings or disagreements concerning payment for professional services.

1. Financially you will be responsible for all charges for services rendered.
2. If the patient is a minor (18 years and not emancipated), the parent or guardian must sign below. The parent or guardian who presents with the minor is responsible for any payment due at the time of service.
3. It is our policy not to exceed more than $150.00. We reserve the right to terminate professional care if your balance exceeds the $150.00. Watkins Total Healthcare offers multiple payment plans, please speak with one of our team members for more information.
4. Returned checks must be paid by cash, money order, cashier's check or credit card. The fee for a returned check is $15.00 per check and payment with a check will no longer be accepted.
5. All massages are subject to a 24 hour cancellation notice. Outside of a 24 hour notice there will be no charge for cancellation, however, inside the 24 hour notice you will be responsible for the full charge for the service.

By hereby signing this financial policy, I state that I fully understand all statements made herein and that any questions I have about the financial policy of Watkins Total Healthcare have been answered in full.

_____ _____

Patient or Parent/Guardian Signature Date

There is no higher privilege than you as a patient making referrals of a family member or friend to this office. We welcome your referrals and look forward to a doctor/patient relationship with you.

Watkins Total Healthcare, LLC

961 Green Street NE
Gainesville, GA 30501
Phone: (770) 534-0656

Dear Patient:

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT
We now offer the following payment options:

___ **Payment by cash**

___ **Payment by check**

___ **Payment by credit card**

___ **Automatic monthly billing to your Visa or MasterCard**

___ **Guarantee any amount not covered by insurance with Visa or MasterCard.**

Please make your choice, sign below and return to Director of Patient Services before treatment.

Our office is a fully approved and accredited user of the *Visa and MasterCard Health Care Program* which will enable you to use your Visa and MasterCard to automatically cover amounts not paid by your insurance. You may also choose a comfortable amount to be automatically billed to your Visa or MasterCard on a monthly basis.

If none of the above apply, please see Director of Patient Services. Thank you.

_____
Print your name here and sign below

*x*_____
Date:_____