PATIENT REGISTRATION FORM (Please Print)

PATIENT'S Last Name, First, Middle Initial _____ School, if student or if applicable _____

Birth Date _____ M or F (Circle One) PIN/Social Security Number _____

Address _____ City _____ State _____ County _____ Zip Code _____

Phone Numbers: Home: ( ) _____ Work: ( ) _____ Cell: ( ) _____

In case of emergency, or should we need to cancel because of illness, weather, etc., please list information on how to contact you, including a work phone number:

_____

Please list other members of household:

_____ _____

_____ _____

_____ _____

Payment and Policy Agreement:

I agree to make payment at time of service (unless another agreement is reached - in writing). In the event a balance is accrued, I agree to pay all incurred expenses within 30 days of each billing statement. If payment in full is not made within 10 days after the scheduled due date for any billing, I further agree to pay a late charge (in addition to the original balance) in the amount of 1.5% of the unpaid balance. I understand that if payment is not made on a timely basis as agreed, then appropriate steps may be taken to collect sums owed - which may include sending the delinquent account to a collection agency and the pursuit of other legal remedies.

I hereby acknowledge receipt of "To My Clients," information regarding policies and procedures. I agree to the conditions stated therein.

Date: _____ _____

_____
(Person(s) responsible for payment)