South Square Chiropractic, PLLC

DR. CHESTER PALUMBO

DATE _____

PATIENT NAME (Print) _____

ADDRESS _____

CITY _____ STATE _____ ZIP_____

HOME PHONE _____ WORK PHONE _____

CELL PHONE _____ E-MAIL _____

SOC.SECUR. # _____ BIRTHDATE _____

May we make a copy of your Driver's license? YES / NO

EMPLOYER _____

INSURANCE CARRIER _____

POLICY NUMBER _____ GROUP NUMBER_____

ARE YOU THE INSURED? _____ IF NOT, GIVE NAME AND BIRTHDATE:

Name _____ Birthdate _____

MARITAL STATUS [Optional] M S D W

REFERRED BY _____

I understand and acknowledge that I am personally responsible and liable for all charges and services incurred at South Square Chiropractic, PLLC. Insurance is filed as a courtesy. Any denial or non-payment by the insurance carrier is my responsibility, including any balance. All fees, co-payments or deductibles are payable at each session. Having read the policies stated, I hereby agree to the terms and conditions stated. I have read and do understand the Notice of Privacy Practices, as described by South Square Chiropractic, PLLC. I understand any treatment may carry a level of risk, and I give my full consent to South Square Chiropractic, PLLC to treat me according to accepted standards approved by the state of North Carolina.

PATIENT SIGNATURE _____ DATE _____