Name: ____ DOB: _____/_____/_____ Age: ______
First Middle Initial Last

Address: ____
Street City State Zip

Social Security #: ___________ - ___________ - _________ Sex: M F Marital Status: S M D W Sep

Home #: ( ) _____ - __________ Cell #: ( ) _______ -___________ Work # ( ) _____ - ___________

Employer: ______________________________________ Occupation: ____________________________

Email : ______________________________________ (work / home) # of children _______________

Spouse's Name: _____________________ DOB: _____/_____/_____ Employer: _______________________

Name of Closest Relative not living with you: ____

Address: ____ Phone #: ( ) ________ - _____________

(Please read and initial each section)

General Consent:

* I consent to treatment necessary for my medical care by Dr. Larry A. Bompiani and his staff.
* I give Dr. Larry A. Bompiani permission to release any information that he has acquired in my case to my insurance company and/or attorney.
* I authorize Dr. Larry A. Bompiani to obtain any and all medical records from other providers as they pertain to my care.
* I direct any and all insurance carriers and/or attorneys which may be obligated to pay benefits to me for my medical condition be paid directly to Dr. Larry A. Bompiani for services rendered. **Initials:** __________

Appointment Policy:

* I understand that I will be charged a $40 non-cancellation fee for any appointment that I have scheduled for which I do not show or call in advance of the appointment time to cancel. This charge will not be billed to my insurance carrier and I understand that I will be responsible for payment. Failure to pay this fee will be treated the same as any other unpaid balance on my account which is subject to interest and collections. **Initials:** __________

Financial Policy:

* I understand that regardless of my insurance coverage, I am ultimately responsible for **all** medical services rendered to me in this office and realize that my charges will be filed to my primary insurance carrier as a courtesy.
* I agree to pay all charges whether co-pays, coinsurance and/or patient liability balances (as determined by my insurance Explanation of Benefits) at the time of service.
* I understand the financial policy set forth by Bompiani Chiropractic Center, Inc. and agree to these terms.

Initials: __________

Patient Signature: ______________________________________ Date: __________________________

FINANCIAL DATA SHEET