



Date _____

Name _____ Social Security # _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

E-mail Address _____ Fax # _____ Cell _____

Age _____ Birth Date _____ Marital Status : M S W D

Occupation _____ Employer _____

Employer's Address _____ Office Phone _____

How were you referred to our office? _____

Purpose of this appointment _____

Date symptoms appeared or accident happened? _____

Days lost from work _____

What medications or drugs are you taking? _____

Please check any and all insurance coverage that may be applicable in this case.

Major Medical Worker's Compensation Medicaid Auto Accident Other

Name of Primary Insurance Company _____

Name of Secondary Insurance Company (if any) _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to Dr. Bond or the doctor's office. I authorize the doctor to release all information necessary to communicate with personal physicians and other health care providers and payers and to secure the payment benefits. I understand that I am responsible for all cost regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 16 percent.

The patient understands and agrees to allow the Doctor's office to use their Patient Health Information for the purpose of treatment payment, healthcare operations and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature _____ Date _____