

CONFIDENTIAL

DR. KATE KLEMER

PATIENT/INSURANCE INFORMATION

NAME _____ SSN _____ D.O.B. _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE (H) _____ (W) _____ (C) _____

E-MAIL _____ REFERRED BY _____

HAVE YOU HAD CHIROPRACTIC BEFORE? YES / NO

EMERGENCY CONTACT _____ RELATIONSHIP _____

ADDRESS _____ PHONE _____

EMPLOYER _____ OCCUPATION _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

Was this health condition caused by a car accident or work related? Yes / No

There is a \$50.00 charge for appointments broken without 24-hour prior notice.

INSURANCE INFORMATION

INSURANCE COMPANY _____

NAME OF INSURED _____ Self Spouse Parent Other _____

POLICY # _____ GROUP # _____

DEDUCTIBLE \$ _____ CO-PAY _____ COPY BOTH SIDES OF CARD? Yes / No

- For each visit you will need to pay the estimated percentage of the charges not covered by your insurance. This may include co-payments, deductibles and co-insurance.
- You will be billed for any amounts not paid at the time of service that are not covered by your insurance.
- Any amount not covered by your insurance must be paid within 30 days of being billed.
- Craniosacral therapy and nutritional care are not covered by insurance. One of these treatments is included in all 30 or 45 minute appointments.
- All charges rendered for services and/or products are the responsibility of the patient.
- We accept cash, checks or credit cards.

I have read, understand and agree to the above policies.

PATIENT SIGNATURE _____ DATE _____

WITNESS SIGNATURE _____ DATE _____

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DR. KATE KLEMER

PATIENT INFORMATION (SELF PAY)

NAME _____	SSN _____	D.O.B. _____
ADDRESS _____	CITY _____	STATE _____ ZIP _____
PHONE (H) _____	(W) _____	(C) _____
E-MAIL _____	REFERRED BY _____	
HAVE YOU HAD CHIROPRACTIC BEFORE? YES / NO		
EMERGENCY CONTACT _____	RELATIONSHIP _____	
ADDRESS _____	PHONE _____	
EMPLOYER _____	OCCUPATION _____	
ADDRESS _____	CITY _____	STATE _____ ZIP _____
Was this health condition caused by a car accident or work related? Yes / No		
There is a \$50.00 charge for appointments broken without 24-hour prior notice.		

- Payment is due at the time of service. We accept cash, checks or credit cards.
- There is a discount if full payment is received at the time of service.
- If I get billed for services, I will not receive the discount and will be billed at full price.
- I understand that if I am billed, I agree to pay the full amount charged to me.

I have read, understand and agree to the above policies.

PATIENT SIGNATURE _____ DATE _____

WITNESS SIGNATURE _____ DATE _____