Application for Treatment with Dr. Susan D. Player

Name (last) ____________ (first) ____________ (middle) ________ Occupation: ____________

Address ____________
____
City / State / Postal code ____________
Country ____________
e-Mail: ____________
Phone numbers Hm (   ) ____________
Cell (   ) ____________
Wk (   ) ____________
Fax (   ) ____________

Local address ____________
(if visiting Clearwater) ____________
City / State / Zip ____________

Local phone numbers
Hm (   ) ____________
Cell (   ) ____________
Wk (   ) ____________
Fax (   ) ____________

What kind of health care are you interested in?
O Preventative O Short term O Long term O Second Opinion

What is your goal(s) regarding your health (be specific)? ____________

____

Marital Status (check 1):
O Single O Married O Widowed
O Divorced O Separated
Name of husband or wife:
____
Number of children: ________
Children's ages: ________

Sex:
O Male O Female

Date of Birth:
____
(mo/day/yr)

Do you have insurance that covers chiropractic?
O Yes O No
Social Security Number ____________
Medicare Number ____________

Have you consulted another health advisor (s) for this problem?
O No
O Yes: name: ____________ specialty ____________

How did you hear about Dr. Player (check all that apply)?
O Referral (whom may we thank for referring you?):
____
O Website O Newsletter in mail
O Flyer handed-out
O Newspaper/Mag article (what publication) ________
O Yellow Pages
O Other Directory (which) ____________
O Other (specify) ____________

What did you hear or read about Dr. Player that interested you in coming here now?
____
____

Agreements:

I understand that after my exam, Dr. Player will determine if care in this office is appropriate for my situation and will accept me on that basis.

I agree to pay for all services and supplements at the time they are rendered with either cash, personal check or accepted credit card.

I also agree to pay in full for any appointments that I do not keep or am late for. Any appointments that I change with less than 24 hours notice will be charged in full. In the case that the office is closed, a message left on the answering machine at least 24 hours prior to the scheduled appointment will count as proper notice. If I am late I will receive care for the balance of my scheduled appointment only.

Should it occur that Dr. Susan D. Player is late for scheduled appointments, I will receive that amount of treatment time missed at no charge.

A $20 service charge is made for all checks returned unpaid.

The cost of the initial consultation, exam and report of findings is usually $350-425 depending upon the complexity of my health situation. If any additional tests are needed, I will be informed of their cost. I will pay $425 in advance to reserve the 3 appointments. If the appointments don't cost the full $425, the remainder will be applied toward future treatment.

I realize that in order for me to attain the full benefits of treatment, it is important that I become oriented to Dr. Player's diagnosis and treatment methods. **I therefore agree to read and apply the information that Dr. Player gives to me regarding my health conditions.**

Signature: ____________ Date: ______

Signature: ____________ Date: ______
Parent/Legal Guardian if under 18