

**LAKE CHIROPRACTIC**  
 3017 PUMP HOUSE ROAD CAHABA HEIGHTS, AL 35243  
 PHONE: 205.380.0574 FAX: 205.968.5854

**Patient Information**

Today's Date:	SSN#:
Full Name:	Driver's License#
Nickname: <small>(you would like to be called)</small>	Employer: Full Time/ Part Time/ Retired
Address:	Work Address:
City:	
State:                    ZIP:	
Home Phone:	Work Phone:
Cell Phone:	Insurance Co./Contract #:
Email:	Spouse:
Date Of Birth:	Spouse's Employer:
Gender:    Male / Female	Insured:
Marital Status: Single/ Married	Insured Date Of Birth:
Referred By?	Insured Social Security Number:
What Brings You In Today?	Relationship to Insured:

**Consent for Care and Authorization to Perform X-Rays**

\_\_\_\_\_ I authorize Lake Chiropractic (LC) to analyze for Subluxation and administer care that is deemed necessary.  
initials

\_\_\_\_\_ If X-rays are deemed necessary for complete analysis of my health challenge, I authorize LC to perform such  
initials radiographic examinations.

**Fees For Services Rendered**

\_\_\_\_\_ **Fees are payable when service is rendered unless other arrangements have been made in advance.**  
initials Insurance co-payments are due at time of service. Ancillary services will be an additional fee. Fees are subject to change without notice. Return checks are subject to a \$35 fee.

**For Your Convenience**

\_\_\_\_\_ I authorize LC to release any information or office records to my insurance company  
initials or lawyer. I authorize the release and the payment of health benefits to LC and the respective doctor. This is to serve as a long-term authorization.

**Overdue Accounts**

\_\_\_\_\_ If my account is overdue by 60 days LC will send this account to a collection agency or  
initials attorney for collection. Any/All fees including collection percentages will be added to the unpaid balance and be the sole responsibility of the undersigned. Collection fees, Attorney fees and court costs will be the sole responsibility of the undersigned. If you do not agree to the collection policy then it will be necessary to collect fees prior to services rendered.

**Acknowledgement of Notice of Privacy Practices**

\_\_\_\_\_ I hereby acknowledge that I have received the Notice of Privacy Practices statement of LC.  
initials

Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Print Name \_\_\_\_\_ LC Rep \_\_\_\_\_