John J. Bolte B.S.,D.C.,F.I.A.C.A.,
Chiropractic Physician
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The Get Well Center

NAME_____DATE_____

ADDRESS_____CITY_____STATE_____ZIP_____

P.O. BOX_____ E-MAIL_____

PHONES: HM_____BUS_____CELL_____

AGE_____BIRTH DATE_____SS#_____OCCUPATION_____

SPOUSE NAME_____BIRTH DATE_____

INSURANCE COVERAGE YES / NO (PLEASE PRESENT US YOUR CARD SO WE CAN MAKE A COPY).

IS THIS OFFICE VISIT THE RESULT OF:
____SICKNESS ____AUTO ACCIDENT ____JOB INJURY ____OTHER_____

WHOM MAY WE THANK FOR REFERRING YOU:_____

PLEASE CHECK WHICH TYPE OF CARE YOUR SEEKING:
____RELIEF ____CORRECTIVE ____OPTIMAL WELLNESS

I hereby give permission to the doctor to release any information requested by my insurance company acquired in the course of my child, ward, or my examination and treatment.

I hereby give permission for the doctor to charge a $25.00 no show fee in the event that I do not give notice 24 hours in advance of my inability to make my scheduled appointment.

I hereby authorize and direct my insurance benefits to be paid directly to the doctor. I am financially responsible for non-covered services.

I hereby give permission to the doctor to administer treatment and perform such general procedures, as he may deem necessary in the diagnosis and / or treatment of my child, ward, or my condition.

In the event of default, the patient, parent or legal guardian agrees to pay all collection cost incurred to collect the balance due. Patient, parent or legal guardian is responsible for all attorney fees, court costs and other fees incurred to collect the balance owed.

SIGNATURE_____DATE_____

I HAVE READ AND AGREE TO THE ABOVE STATEMENTS