Mariner CHIROPRACTIC Center

PHONE: 360-692-5350 **FAX: 360-692-5354**

Dr. Corey H. Findlay D.C.

PATIENT REGISTRATION

Name: First: _____ **MI**: ____ **Last**: _____

Sex: M ☐ F ☐ **Date of Birth**: **Month**_____ **Day**____ **Year**_____

Address: **Street/PO Box**: _____**City**:_____**State:**_____ **Zip**: _____

Soc. Sec. # _____-___-_____ **Home Phone**: _____ **Cell**: _____ **Work**: _____

E-Mail: _____ **Marital Status**: **M** ☐**S** ☐**D** ☐**W** ☐

Referred By_____ **Have you seen a Chiropractor before?** _____

Nearest Relative: **Name/City:** _____ **Phone #:**_____

Employer: **Name/City:** _____**Phone #:**_____

This visit is the result of: **Auto Accident** ☐ **Injury** ☐ **Accident on the job** ☐ **Other** ☐

FINANCIAL AGREEMENT

1. <u>INSURANCE</u>: This office will bill my insurance company. I will pay my portion of deductibles and co-payments at the time of services rendered.

I hereby authorize my insurance benefits to be paid directly to this office. I also expressly authorize the release of any information necessary to satisfy my claims for services.

2. <u>PAYMENT IN FULL</u>: Payment in full is due at the time services are rendered.

I understand that I am fully responsible to the doctor, or his office, for all health care bills submitted. I agree to pay the doctor immediately upon dispersal of any funds from any sources. An additional finance charge of 1.5% per month (beginning the day of disbursement of funds from any source) will be paid by me on any balance remaining for said services. If I suspend or terminate care, any balance for fees will be immediately due and payable.

Patient/Guardian Signature: _____ Date: _____