

TOBEY CHIROPRACTIC

"Find it, Fix it, Leave it alone"

NAME _____ DATE OF BIRTH _____

ADDRESS _____ CITY, STATE, ZIP _____

HOME PHONE _____ CELL PHONE _____

(DO YOU PREFER US TO CONTACT ON YOUR HOME PHONE OR CELL PHONE WHEN NECESSARY? HOME CELL)

EMAIL ADDRESS _____

(YOUR EMAIL WILL NOT BE SHARED WITH ANY THIRD PARTIES AND IS USED FOR OFFICE ANNOUNCEMENTS, MONTHLY NEWSLETTERS AND PROMOTIONS ONLY)

SEX MALE FEMALE ARE YOU: ___A MINOR ___SINGLE ___MARRIED SPOUSE'S NAME _____

IS YOUR VISIT DUE TO: ___AN AUTO ACCIDENT ___A WORK ACCIDENT ___OTHER ACCIDENT ___NONE

WILL YOU BE PAYING CASH OR ARE WE BILLING INSURANCE FOR YOU? ___CASH ___INSURANCE

(PLEASE BRING YOUR INSURANCE CARD TO THE FRONT DESK SO WE MAY GET A COPY OF IT FOR YOUR FILE. THANK YOU)

INSURANCE PATIENTS ONLY: SS# _____ SPOUSE'S SS# _____

SPOUSE'S BIRTH DATE _____ EMPLOYER OF INSURED _____

FEES AND PAYMENT POLICY

Consultation	No charge	Examination	\$35-\$100 depending on complexity
Xrays	\$100 per set (\$30)	Spinal Adjustments	\$65 (\$45)
Therapies	\$35 per modality (\$10 with spinal adjustment. Full price if modality only.)		

We offer a time of service discount to our cash paying patients to pass on our savings in billing costs. All time of service fees are posted in parenthesis () above next to the usual and customary fees.

We invite you to discuss with us any questions regarding your care and our fees/services. We believe that the best health services are based on a friendly, mutual understanding between patient and provider.

X
INITIAL

We will bill your insurance as a courtesy to you. Please understand that health/accident insurance policies are an arrangement between your insurance carrier and yourself. Also understand and agree that all services rendered to you and charged are your personal responsibility for timely payment.

Money Back Offer: Since everyone is different, we cannot guarantee results but we can promise your satisfaction. If **within 7 days** you are not happy with your decision to begin care at our clinic and see no improvement in symptoms or mobility while following our treatment protocol; we will refund any money that you paid for treatment (spinal adjustments and therapies.) It does not include a refund for examination or Xrays nor charges billed to your insurance.

I have read and understand the above policies and agree to begin care by Dr Tobey.

Patient Signature _____ Date _____