

## PATIENT INFORMATION

Date \_\_\_\_\_ Case Number \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex  Male  Female

Social Security Number \_\_\_\_\_ Marital Status : S  M  D  W

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone #'s: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

List preference of contact order (#1,#2,#3)

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Spouse/ Guardian \_\_\_\_\_ Employer \_\_\_\_\_

Work Phone \_\_\_\_\_ Social Security Number \_\_\_\_\_

Referred by \_\_\_\_\_

In case of emergency contact:

Name \_\_\_\_\_ Phone \_\_\_\_\_

Relationship to you \_\_\_\_\_

Nearest Relative (not living with you):

Name \_\_\_\_\_ Phone \_\_\_\_\_

Relationship to you \_\_\_\_\_

Physician:

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Who is financially responsible for this bill? \_\_\_\_\_

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. As medical care providers, our relationship is with you, not your insurance company. While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered.

\_\_\_\_\_  
Signature of patient (parent/ guardian if minor)

Date \_\_\_\_\_

## Acknowledgement of Receipt of Notice

Ochsner Chiropractic Centre 7877 S. Sheridan Tulsa, OK 74133

Name of Patient \_\_\_\_\_

I hereby acknowledge that I have been presented with a copy of this medical practice's Notice of Privacy Practices.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

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### MESSAGE THERAPY APPOINTMENTS

Ochsner Chiropractic Centre is proud to offer our patients the services of our licensed massage therapists. Should one of our doctors refer you for an appointment with one of our massage therapists, there are a few things that we would like for you to be aware of:

1. Appointments are scheduled on 45-minute intervals. Therefore, it is important that you be timely for your appointment
2. We understand that emergencies do arise; however, should you need to cancel an appointment, we ask that you give us a minimum of 24 hours notice. This allows us time to then find a replacement for your scheduled appointment.
3. In the event that an appointment is missed but not canceled (and it is not a family emergency), there will be a \$20 charge to you.
4. If you request a double massage (90 minutes), the second 45-minute appointment charge will not be filed with patient's insurance and the patient is financially responsible for this portion.
5. We will attempt to give you a reminder call on the workday prior to your massage appointment.

If you are unable to participate under these guidelines, please discuss this with our doctors.

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I have read and understand the above massage appointment criteria.

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Date