WELCOME

The doctor and staff of **Dr. Lynn Carter, Inc.** welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care, we will not accept you as a patient but will refer you to another health care provider, if appropriate.

INSURANCE

Payment is due when service is rendered. However, this office will process your insurance forms upon request. We will do our utmost to provide sufficient information to your carrier to obtain payment for your treatment. We have found that, in some instances, however, insurance companies will deny or reduce payment despite our best efforts to demonstrate the necessity for care. In the event that full payment is not made for any reason, you are responsible to make payment in full.

PATIENT IDENTIFICATION

Name ___________________________________ **Name I prefer to be called** __________________

Address _________________________________ **Home Phone** _______________________________

Address _________________________________ **Mobile Phone** ______________________________

City, State, Zip ___________________________ **Work Phone** _______________________________

Email Address ___________________________ **May we call at work? Yes( ) No( )**

Social Security No. ________________________ **Occupation** _______________________________

Male ( ) Female ( ) **Date of Birth** __________________ **Age** _______

ACCEPTANCE AS PATIENT

I understand and agree that the doctor of **Dr. Lynn Carter, Inc**. has the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process if information gathering so that the doctor can determine whether to accept me as a patient.

Signature **Date**