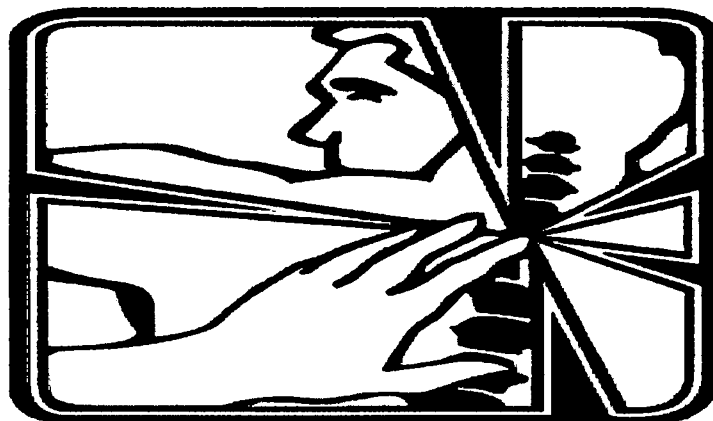

Miracles Happen

Health 1st

FAMILY HEALTH CARE

Health-1st.org

PATIENT APPLICATION FORM

WELCOME TO OUR CLINIC. We specialize in assisting our patients to achieve their highest level of health through our spinal and postural corrective programs. Our approach is very unique and advanced from other rehabilitative programs. This allows our patients to achieve far superior results compared to most other systems.

Please fill out the following information thoroughly so the doctor can let you know if you are a case we can accept. Please feel free to ask any questions if you need assistance. We look forward to serving you.

____
Patient Signature:

____
Today's Date:

____
File #:

Miracles Happen

Health 1st

FAMILY HEALTH CARE

1927 21st Street
Bakersfield, CA 93301
661-324-4431 FAX:661-324-5616

The purpose of our chiropractic clinic is to support each individual in achieving their optimum health and to educate them so that they may understand health and chiropractic and in turn educate others.

To The New Patient

Outline of Procedure for New Practice Members:

- Step One: all new practice members are requested to fill out a personal health history questionnaire and a car accident form and or work compensation form if applicable.
- Step two: Your first consultation will be to discuss your health problems.
- Step Three: Chiropractic Diagnostic, orthopedic and neurological Examination procedures to determine if Chiropractic Care is appropriate for your problem.
- Step Four: You will be advised as to the need for additional procedures such as x-rays or laboratory tests, if necessary.
- Step Five: If your case requires immediate attention, care will be administered.
- Step Six: You will be advised when to return for a "Report of Findings" when Dr. Booth will inform you of your exam results and whether your case has been accepted. Insurance and financial arrangements will be discussed.
- Step Seven: A Corrective Care Program will be recommended based upon your needs.
- Step Eight: Chiropractic Care will begin and your case will be monitored with re-exams and re-x-rays as needed until your condition has been fully corrected or until maximum improvement has been obtained.

PATIENT APPLICATION SURVEY

Name: ________________________________ (Age) ______ Gender: M F

Home Address: ________________________________ Home Phone: ( ) ______________

City, State, Zip: ________________________________ Work Phone: ( ) ______________

Email Address: ________________________________ Cell Phone: ( ) ______________

Birth Date: _____/_____/______ Social Security #: _______-_____-________ Marital Status: S M D W

Names of Children: ________________________________ Ages: ______________

Occupation: ________________________________ Employer Name: ______________

Spouse's Name: ______________ Work Phone: ( ) ______________ Cell Phone: ( ) ______________

Spouse's Employer: ________________________________ Occupation: ______________

How were you referred to this office? ________________________________

PURPOSE OF THIS VISIT

Reason for this visit – Main Complaint: ________________________________

What caused this problem: ________________________________

Doctors seen for this problem: ________________________________

If disabled from work please give dates: ________________________________

Drugs you now take:: ☐ nerve pills ☐ pain killers/ muscle relaxers ☐ blood pressure pills ☐ allergy pills ☐ cholesterol pills

☐ insulin ☐ other

Please check or describe:

Does anyone else in your family have the same or similar condition?

Who ________________________________

Major surgery/operations: ☐ appendectomy ☐ tonsillectomy ☐ gall bladder ☐ hernia ☐ broken bones ☐ other ______________

Major Accidents or Falls: ________________________________

____

Hospitalization (other than above): ________________________________

____

Is this purpose related to an auto accident / work injury? Yes No If so, when: ______________

When did this condition begin? _________/_____/_______ Did it begin: Gradual Sudden Progressive over time

What activities aggravate your symptoms? ________________________________

____

Is there anything, which has relieved your symptoms? Yes No Describe: ______________

Type of Pain: Sharp Dull Ache Burn Throb Spasm Numb Tingling Shooting

Does the Pain Radiate into your: ___Arm ___Leg ___Does not radiate Is this condition getting worse? Yes No

How often do you experience these symptoms throughout the day?: 100% 75% 50% 25% 10% Only with Activity

Does complaint(s) interfere with: __Work __Sleep __Hobbies __Daily Routine Explain: ______________

____

Have you experienced this condition before? Yes No If so, please explain: ______________

EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor before? ⚲ Yes ⚲ No Who? ______________________________ When? ____________________

Reason for visits: ____

How did you respond? ____

Did your previous chiropractor take before and after x-rays? ⚲ Yes ⚲ No

Did you know posture determines your health? ⚲ Yes ⚲ No

Are you aware of any of your poor posture habits? ⚲ Yes ⚲ No

Explain: ____

Are you aware of any poor posture habits in your spouse or children? ⚲ Yes ⚲ No

Explain: ____

The most common postural weakness is Forward Head Syndrome (head and neck starting to bend forward and progressively moving downward weakening your whole body). Even less severe forms of this posture can cause many adverse effects on your overall health. Have you ever been told or felt like you carry your head forward, noticed a rounding of your shoulders or a developing "hump" at the base of your neck? Yes No

PERSONAL HISTORY

Vaccinations & Injections:
□ smallpox □ polio □ DPT □ tetanus: date__________ □ flu □ measles □ hepatitis □ spinal tap □ other______________

Radiology:
□ previous x-rays__________________________ □ cat scan__________________ □ MRI____________________
Do you exercise? Yes No How often? 1X 2X 3X 4X 5X per week other: ______________ _______

What activities? Running Jogging Weight Training Cycling Yoga Pilates Swimming ____________________

Do you smoke? Yes No How much?

____

Do you drink alcohol? Yes No How much / week?

____

Do you drink coffee? Yes No How many cups / day?

____

Do you take any supplements (i.e. vitamins, minerals, herbs)?

____

Sleep during the night? Yes No How many hours?

____

FAMILY HEALTH HISTORY

Abnormal postural habits or distortions are the result of trauma or stress to the body that have misaligned the vertebrae in your spine. When these vertebrae are twisted from their normal position, they will cause stress to the spinal cord and the delicate nerves that pass between the vertebrae. These misalignments are called Subluxations (sub-lux-a-shuns). It has been extensively documented that subluxations, causing stress to your nerves, will weaken and distort the overall structure of your spine. This results in a weakened and distorted POSTURE. Postural distortions have many serious and adverse effects on your overall health. The most common and detrimental postural distortion is called Forward Head Syndrome (a "hunched forward" posture starting in the neck and progressively moving down your spine weakening the entire body).

Please Describe:

Father: ______________________________ Mother: ______________________________

Brothers/Sisters: ____

Is any member of your family ill or doctoring with any condition? ______________________

Please check the type of care you desire so that we may be guided by your wishes whenever possible.

Why Chiropractic? People go to Doctors of Chiropractic for a variety of reasons. Some go for symptomatic relief of pain (Relief Care). Others are interested in having the cause of their problem as well as the symptoms corrected (Corrective Care). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible (Comprehensive Care). Your Doctor will weigh your needs and desires when recommending your care program.

☐ **Relief Care**

☐ **Corrective Care**

☐ **Comprehensive Care**

☐ **Check here if you want the Doctor to select the appropriate care for your condition.**

Patient Name ______________________________ Date ______________

SYMPTOMS OF SPINAL MISALIGNMENT QUESTIONNAIRE

"The nervous system controls and coordinates all organs and structures of the human body." (Gray's Anatomy, 29th Ed., page 4). Misalignments of spinal vertebrae and discs may cause irritation to the nervous system and affect the structures, organs, and functions which may result in the conditions shown below. Please help us help you by placing a check mark in the appropriate box under the "Possible Effects" column to indicate your symptoms.

ATLAS
AXIS
CERVICAL SPINE
1st THORACIC
THORACIC SPINE
1st LUMBAR
LUMBAR SPINE
SACRUM
COCCYX

Vertebrae	Areas Controlled by Nerves*	Region	Possible Effects of a Malfunction
1C	Blood supply to the head, pituitary gland, scalp, bones of the face, brain, inner and middle ear, sympathetic nervous system.		☐ headaches, ☐ nervousness, ☐ insomnia, ☐ head colds, ☐ high blood pressure, ☐ migraine headaches, ☐ nervous breakdowns, ☐ amnesia, ☐ chronic tiredness, ☐ dizziness.
2C	Eyes, optic nerves, auditory nerves, sinus, mastoid bones, tongue, forehead.		☐ sinus trouble, ☐ allergies, ☐ crossed eyes, ☐ deafness, ☐ eye troubles, ☐ earache, ☐ fainting spells, ☐ vision difficulties.
3C	Cheeks, outer ear, face bones, teeth, trifacial nerve.	NECK REGION	☐ neuralgia, ☐ neuritis, ☐ acne or pimples, ☐ eczema.
4C	Nose, lips, mouth, eustachian tube.	NECK REGION	☐ hay fever, ☐ hearing loss, ☐ adenoids.
5C	Vocal cords, neck glands, pharynx.	NECK REGION	☐ laryngitis, ☐ hoarseness, ☐ sore throats, ☐ quincy.
6C	Neck muscles, shoulders, tonsils.	NECK REGION	☐ stiff neck, ☐ pain in upper arm, ☐ tonsillitis, ☐ whooping cough, ☐ croup.
7C	Thyroid gland, bursae in the shoulder, elbows.		☐ bursitis, ☐ colds, ☐ thyroid conditions.
1T	Arms from the elbows down, including hands, wrists, and fingers; esophagus and trachea.		☐ asthma, ☐ cough, ☐ difficult breathing, ☐ shortness of breath, ☐ pain in lower arm, ☐ pain in hands.
2T	Heart, including its valves and covering; coronary arteries.		☐ functional heart conditions, ☐ chest conditions.
3T	Lungs, bronchial tubes, pleura, chest, breast.		☐ bronchitis, ☐ pleurisy, ☐ pneumonia, ☐ congestion, ☐ influenza.
4T	Gall bladder, common duct.		☐ gall bladder conditions, ☐ jaundice, ☐ shingles.
5T	Liver, solar plexus, blood.	MID-BACK	☐ liver conditions, ☐ fevers, ☐ low blood pressure, ☐ anemia, ☐ poor circulation, ☐ arthritis.
6T	Stomach.	MID-BACK	☐ stomach troubles, ☐ nervous stomach, ☐ indigestion, ☐ heartburn, ☐ dyspepsia.
7T	Pancreas, duodenum.	MID-BACK	☐ ulcers, ☐ gastritis.
8T	Spleen.	MID-BACK	☐ low resistance to colds and disease.
9T	Adrenal and supra-renal glands.		☐ allergies, ☐ hives.
10T	Kidneys.		☐ kidney troubles, ☐ hardening of the arteries, ☐ chronic tiredness, ☐ nephritis, ☐ pyelitis.
11T	Kidneys, ureters.		☐ acne, ☐ pimples, ☐ eczema, ☐ boils.
12T	Small intestines, lymph circulation.		☐ rheumatism, ☐ gas pains, ☐ sterility.
1L	Large intestines, inguinal rings.		☐ constipation, ☐ colitis, ☐ dysentery, ☐ diarrhea, ☐ ruptures, ☐ hernias.
2L	Appendix, abdomen, upper leg.		☐ cramps, ☐ difficult breathing, ☐ acidosis, ☐ varicose veins.
3L	Sex organs, uterus, bladder, knees.	LOW BACK	☐ bladder troubles, ☐ menstrual troubles such as painful or irregular periods, ☐ miscarriages, ☐ bed wetting, ☐ impotency, ☐ change of life symptoms, ☐ knee pains.
4L	Prostate gland, muscles of the lower back, sciatic nerve.	LOW BACK	☐ sciatica, ☐ lumbago, ☐ difficult, painful, or too frequent urination, ☐ backaches.
5L	Lower legs, ankles, feet.	LOW BACK	☐ poor circulation in the legs, ☐ swollen ankles, ☐ weak ankles and arches, ☐ cold feet, ☐ weakness in the legs, ☐ leg cramps.
SACRUM	Hip bones, buttocks.	PELVIS	☐ low back pain, ☐ spinal curvature.
COCCYX	Rectum, anus.	PELVIS	☐ hemorrhoids (piles), ☐ pruritis (itching), ☐ pain at end of spine on sitting.

* Directly or indirectly controlled

For further explanation of the conditions shown above, and information about those not shown, ask your Doctor of Chiropractic

EXPAND CHIROPRACTIC PRODUCTS Form 021
1-800-548-3676 COPYRIGHT DAVID SINGER, 1992

TERMS OF ACCEPTANCE

When a person seeks chiropractic and rehabilitation health care and is accepted for such care, it is essential for both parties to be working towards the same objective. As a Chiropractic & Rehab facility we have one main goal, to detect and correct/reduce the vertebral subluxation complex. It is important that each person understand both the objective and the method that will be used to attain this goal. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat a disease or condition other than vertebral subluxation. Regardless of what a disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **Our Only Practice Objective** is to eliminate a major interference to the expression of the body's innate wisdom and ability to heal. Our only method is specific adjusting to correct vertebral subluxations combined with rehabilitation procedures. NOTE: It is understood and agreed the amount paid to Health-1st for x-ray, is for examination only and the x-rays will remain the property of this office, being on file where they may be seen at any time while a patient of this office.

CONSENT TO CARE

I do hereby authorize Dr. Booth/ Health-1st to administer such care that is necessary for my particular case. This care may include consultation, examination, spinal adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays or any other procedure that is advisable, and necessary for my health care.

Furthermore, I authorize and agree to allow the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration to allow for normal bio-mechanical motion and neurological function.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures related to my health care. I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I understand and informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to fractures, disk injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. The doctor will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions treated at this clinic.

I also clearly understand that if I do not follow Dr. Booth's specific recommendations at this clinic that I will not receive the full benefit from the programs offered, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the Doctor for all services rendered. I also understand any sum of money paid under assignment by any insurance company shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the doctor.

I acknowledge and understand that if **Scar Tissue Remodeling/ Graston Technique** is prescribed by Dr. Vincent Booth, it may cause any and all of the following: **pain, swelling, edema, redness, stiffness, soreness, and bruising,** all of which can range from minor to severe in some cases. While highly unlikely, I also realize that like any form of therapy, **Scar Tissue Remodeling** could potentially worsen my condition. I understand all of this and wish to be treated anyway.

Signature:_______________________________________ Date:_____________________

Acknowledgment of Receipt of Notice of Privacy Practices

1927 21st Street
Bakersfield, California 93301661-324-4431
661-324-4431

I understand and have been provided with the opportunity to review a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- ❑ The right to review the notice prior to signing this consent,
- ❑ The right to object to the use of my health information for directory purposes, and
- ❑ The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

California Board of Chiropractic Examiners Authorization

Your chiropractor and members of the practice staff may need to disclose your name, address, phone number, billing information and your clinical records to the California Board of Chiropractic Examiners Authorization. This disclosure will be made if we need the California Board of Chiropractic Examiners Authorization assistance to receive reimbursement for your services or, we need the California Board of Chiropractic Examiners Authorization assistance because the party responsible for reimbursing your services has improperly processed your claim.

By signing this form you are giving us authorization to send the California Board of Chiropractic Examiners Authorization this information. You are also giving the California Board of Chiropractic Examiners Authorization authorization to re-disclose your information to the party responsible for the payment of your services, the California Board of Chiropractic Examiners Authorization legal counsel, and state or federal agencies that may be asked to intercede on your behalf.

Appointment Reminders and Health Care Information Authorization

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on our answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

Patient Signature: ______________________________ Date: ______________

If not signed by the patient, please indicate relationship.

- ❑ Parent or guardian of minor patient
- ❑ Guardian or conservator of an incompetent patient
- ❑ Beneficiary or personal representative of deceased patient

Name of Patient: ______________________________

I, ______________________, have read or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent, and by signing below I agree to the above-above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

Signature_______________________________________ Date ______________ *(If under age 18) Parent's signature*

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle:__________

____ ________________

Signature Date

Consent to x-ray:

I hereby grant Dr. Booth/Health-1st permission to perform an x-ray evaluation if needed of ____________. I understand that x-rays are being performed to locate vertebral subluxation, and not to diagnose or treat any other disease or condition.

____ ________________

Signature (parent if minor) Date

Consent to evaluate and adjust a minor child

I, ______________ being the parent of legal guardian of ________________ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

____ ________________

Signature Date

Consent to take a photo:

I hereby grant Dr. Booth/Health-1st permission to take a photo for the sole use of patient file identification. This photo will never be used for any purpose other than patient identification, nor will this photo or any information be shared with any outside source.

____ ________________

Signature (parent if minor) Date

INSURANCE INFORMATION

I clearly understand that all insurance coverage is an arrangement between my insurance carrier and me. If this office chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience for me. The Doctors office will provide any necessary report or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny any claim and that I am ultimately held responsible for any unpaid balances. Any monies received will be credited to my account. I certify that this office visit is not related to any personal injury or worker's compensation case that is active or that has not been closed and finalized.

Signature_______________________________________ Date ____________________

Health-1st
1927 21st Street
Bakersfield, CA 93301
661-324-4431 Fax: 661-324-5616
healthfirstca@yahoo.com

LAW OF FAIR EXCHANGE

It is important that you have a clear understanding of the Law of Fair Exchange and how it applies to our clinic.

Simply put-if something you do is not valuable, there is no point in doing it. We value Chiropractic and what we do. If Chiropractic is something you chose to make part of your life, then it must be of value to you. This is where the Law of Fair Exchange comes into play. We turn on your Life Force-therefore, there must be some exchange on your part. It is a matter of honor and honesty. What we do is unique and has great value. It is the best service of its kind available anywhere.

In reality, the restoration of Life Force into your body is priceless. How can a dollar amount be placed on something as incredible as that? We want to make this service available for everyone, but we want the interaction to be correct. It is a two-way street.

We are committed to helping patients through tough times. However, balances and payment plans must be carefully monitored. If your balance becomes too high, not only is there no fair exchange, but we are doing a disservice to you and are out of the exchange mode.

The Law of Fair Exchange applies not only within our clinic, but in the everyday activities of all people. In all human interactions there is a law of giving and receiving...a law of equal reciprocity. When there is no fair exchange, there is no affinity and no good results are forthcoming. If you resist giving, you resist receiving. If you resist receiving, you resist giving; each is a function of the other. If you don't give or receive, you can only be what is known as a taker.

Persons receiving adjustments who are "out of the exchange mode" feel guilty, complain, ask for special attention, seldom refer others, get minimal results, find false reasons to quit, and badmouth those in Chiropractic who have tried to help them.

When a Chiropractic adjustment program is done correctly, it is done only once and then merely maintained over your lifetime. It is similar to planting a garden. When you first get started, all the weeds have to be pulled and the soil fertilized. After a few months you have a beautiful garden and now must maintain if to keep it looking beautiful.

If you are among those who see the immense value of having your Life Force flow freely, are committed to change and self improvement, want to make your life work better, are self-responsible and want to maintain your health and prevent disease then we welcome you to our family of patients

"Dedicated to Patient Education and Quality Chiropractic Care"

Sign:______________________________ **Date:**______________

Disclosure of Fees

EXAMS		Insurance	PCD
99203	Intermediate Initial History and Exam	$125.00	$81.00
99212	EP Problem Focused Office Visit (7-10 minutes)	$60.00	$39.00
99213	E/M Low Complex Office Visit (10-15 minutes)	$80.00	$52.00
PROCEDURES			
97110	Therapeutic Exercises (15 minutes or less)	$40.00	$32.00
97012	Intersegmental Traction (decompression)	$75.00	$49.00
97022	Hydro-bed Modality	$40.00	$28.00
97032	Attended Electrical Stimulation	$40.00	$32.00
97140	Manuel Therapy (2 Units/30 minutes)	$110.00	$71.00
97140	Manuel Therapy (4 Units/60 minutes)	$220.00	$143.00
98940	Spinal Manipulation (1-2 regions)	$68.00	$40.00
98941	Spinal Manipulation (3-4 regions)	$70.00	$45.00
98943	Extremity Adjustment	$40.00	$28.00
97012	Intersegmental Traction	$40.00	$28.00
X-RAYS			
72010	Full Spine (2 Views)	$170.00	$110.00
72040	Cervical (3 Views)	$135.00	$88.00
72050	Cervical (5 Views)	$175.00	$115.00
72052	Cervical (7 Views)	$110.00	$71.00
72100	Lumbar (2 Views)	$245.00	$160.00

I have read the above codes and fees and understand the cost of my care with Dr. Booth/ Health-1st. I understand that I am responsible for payment of all deductibles and co-payments related to my care. I understand that if I have a balance for health care services not paid, I will make a minimum payment of $150.00 each month by auto debit or 20% of the outstanding balance, whichever is greater until paid in full. If my balance is not paid in a timely and monthly fashion, I promise to pay any and all collection, court, and attorney fees in the collection of my account. I further understand that if my treatment is associated with a personal injury or accident claim, all my medical bills will be paid at 100% of the above fee schedule regardless of the outcome of my case. I understand that if a check or debit is returned for insufficient funds, I will be charged a $25.00 service charge.

I further understand that if my insurance company declines payment, I authorize Dr. Booth/Health-1st to file small claims on my behalf against my insurance company as a method of collection. I further understand that I will be present at the court date if needed.

I have read and fully understand the above financial terms and prices.

Signed______________________________ **Date**______________

Miracles Happen

Health 1st

FAMILY HEALTH CARE

PERSON ULTIMATELY RESPONSIBLE FOR YOUR ACCOUNT

Name:________________________________ Relationship:_______________________
Billing Address:____________________City:________________ State:______ Zip:___
Home Phone:______________ Work Phone:_____________ Cell Phone:______________
SSN:___-__-___ Driver's License:_________________ State of Issue:_________________
Payment Method: ◻ Cash ◻ Check ◻ Credit Card________________________________
Credit Card#, Exp Date, Security Card

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If the account is not paid within sixty days from the last date of service and no financial arrangement has been made, you will be responsible for all legal fees, collection agency fees, and or any other expenses incurred in collecting for your account.
I understand the above information and guarantee that this form was completed correctly, to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes in my medical status.

I FULLY UNDERSTAND THAT IT IS I AND NOT MY INSURANCE OR ATTORNEY WHO IS RESPONSIBLE FOR ANY BILLS INCURRED AT Dr. Booth / HEALTH-1ST.

Signature:____ **Date:**________________

◻ **Adult patient** ◻ **Parent or Guardian** ◻ **Spouse**