122 E. Walnut Avenue, Suite C
Monrovia, California 91016
(626)358-3800
www.hands2health.com

CONFIDENTIAL PATIENT INFORMATION

Name: _____

Home Phone: _____ Cell Phone: _____

Office Phone: _____ Email: _____

Address: _____

City, State, Zip: _____

Date of Birth: _____ Gender: M ❑ F ❑ Driver's License #: _____

Occupation: _____ S.S. #: _____

Who Referred You?: _____

PAYMENT AND FEE POLICIES

Payment is expected at the time of service. The office accepts Visa, MasterCard and Discover. If you are not able to pay at the time of service, please make other arrangements ***prior*** to your appointment. This will be much appreciated. Ask about different ways to arrange this payment.

If you have insurance, you will be provided with a SuperBill to submit with their claim form. The insurance company will reimburse you. Health and accident insurance policies are an agreement between an insurance carrier and you, the patient. If any information is requested from your insurance company, assistance will be provided. There may be an additional charge depending on the amount of assistance necessary. Returned checks will be charged a $100.00 handling fee in addition to the amount due.

Appointments must be cancelled at least 24 hours in advance. Last minute emergencies are understandable. If you are not able to make your appointment and do not give notice, since there are others waiting, an office visit fee comparable to the visit reserved will be charged.

I have read the payment policies. I understand and agree that all services rendered me are my responsibility. I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. I understand that Dr. Theresa L. Smith, will prepare any necessary reports and forms to assist me in making collection from the insurance company and that there may be an additional charge for reports. I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I consent, authorize and request Dr. Theresa L. Smith, to administer such treatment deemed advisable. I understand that above information and guarantee this form was completed correctly to the best of my knowledge and understand that it is my responsibility to inform the office of any changes in my medical status.

Patient's Signature: __ _____Date: _____