

CranioSacral Institute of Michigan, LLC
245 Barclay Circle, Suite 400 Rochester Hills, MI 48307 (586) 991-0801

PLEASE PRINT

Today's Date _____ Soc. Sec. # _____

Name: Last _____ First _____ M.I. _____ DOB _____

Address _____ City _____ State _____ Zip _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____ Marital Status _____ Sex **M F**

Employer _____

Spouse's Name _____ Birthdate _____ SS# _____

Spouse's Employer _____ Occupation _____

CONTACT IN CASE OF EMERGENCY: _____ Relationship _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

How did you hear about our office? _____

Would you like to receive our newsletter via email? Yes/no Email address: _____

If we have scheduled appointment time for you and you are unable to keep this appointment, please give us 24 hours advance notice. Failure to do so may result in a \$35.00 Missed Appointment Charge.

If you wish to avoid a \$5.00 Service Charge for billings, we request that our charges be paid at the conclusion of each visit..

—FINANCIAL RESPONSIBILITY—

As a medical care provider, our relationship is with you and not with your insurance company (with the exception of valid workman's comp claims). You must realize that some insurance companies do not cover certain services, all charges then are your responsibility. It is also illegal for us to waive deductible and copays specified by your insurance company. Thank you for your understanding and cooperation in this matter.

Patient Signature _____ Date _____

—INSURANCE INFORMATION—

Primary Insurance _____ Subscriber Name _____

Relationship to Patient _____ Policy # _____ Group# _____

Birthdate _____ SS# _____

Secondary Insurance _____ Subscriber Name _____

Relationship to Patient _____ Policy # _____ Group# _____

Birthdate _____ SS# _____

—INSURANCE RELEASE—

I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby certify that I have provided my complete insurance information. I also understand it is my responsibility to notify CranioSacral Institute of Michigan, LLC when any change occurs with my insurance coverage.

I request payment of authorized Medicare, Blue Shield or independent insurance benefits be made either to me or on my behalf to CranioSacral Institute of Michigan, LLC for any services furnished me by them. I authorize any holder of medical information about me to release to the **Centers for Medicare and Medicaid Services** and its agents and information needed to determine these benefits or the benefits payable for the related services.

Date _____ Signed _____