Dr. James E. Hollingsworth
• Chiropractic Physician
• Diplomate American Academy of Pain Management
• Clinical Member American Psychotherapy and
Medical Hypnosis Association

HELPING YOU EXCEL

Name_______________________ Social Security #_______________ Date__________

Address_____________________________ City__________ State_____ Zip______

Home Phone______________ Cell Phone______________ E-Mail Address______________

Birth date ________ Age_____ Marital Status M S W D How many Children?____ Nearest Relative__________

Referred to our office by______________________ Address______________________

Your Occupation__________________ Employer Name______________________

Employer's Address_____________________________ Employer Phone______________

Spouse's Name________________ Soc. Sec. #__________ Spouse's Birth date __________

Employer__________________ Employer's Address______________________

Purpose of this appointment (major complaint)______________________________

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Financial Agreement

Name of person responsible for payment______________________________

Method of payment: Cash_____ Insurance_______ Visa/Mastercard______ Other________________

Payment is expected at time of visit, unless other arrangements are made.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any neccessary reports and forms to assist me in making collections from the insurance carrier and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable and that interest is charged at the rate of 1.5% percent per month (18% per annum) on those amounts 60 days and over. I further authorize and allow Dr. James E. Hollingsworth, associates, and his staff to perform necessary tests and to render appropriate chiropractic care, clinical hypnosis, and counseling.

Patient's signature______________________________

Parent or Guardian ______________________________

Information taken by______________________________ Date__________