SASSEVILLE
CHIROPRACTIC
WELLNESS CENTER

PEDIATRIC INFORMATION

UPDATED 2026 – ONLINE

DATE: _____ / _____ / _______

CHART #: ________________

FULL NAME: ______________________________ DATE OF BIRTH: ____ / ____ / ________

AGE: ________ SSN: ____ - ____ - _____ GENDER: ____________ MARITAL STATUS: ____________

ADDRESS ____

CITY: ______________________________ STATE: ________ ZIP: ____________

HOME PHONE: ______________ CELL PHONE: ______________ E-MAIL: ______________

EMERGENCY CONTACT: ______________________________ PHONE #: ______________

BEST SOURCE OF COMMUNICATION: (CHECK ONE) TEXT EMAIL CALL

HOW DID YOU HEAR ABOUT US? ______________________________

PREFERRED LANGUAGE: ______________ RACE: ______________ ETHNICITY: ______________

EMPLOYERS NAME: ______________________________

OCCUPATION: ______________ WORK PHONE: ______________ EXT: ________

PRIMARY INSURANCE: ______________ SECONDARY INSURANCE: ______________

RELATIONSHIP TO INSURED: (CHECK ONE) SELF SPOUSE CHILD OTHER: ____________

IF SELF; SKIP TO BOTTOM OF FORM. IF SPOUSE, CHILD OR OTHER BE SURE TO FILL OUT ALL OF THE HOLDERS INFORMATION.

NAME OF INSURANCE HOLDER: ______________________ DATE OF BIRTH: ____ / ____ / ________

ADDRESS: ______________________________

SSN: ____ - ____ - _____ EMPLOYER: ______________________ PHONE: ______________

Authorizations: I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment. I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon 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 and treatment, any fees for products or professional services rendered will be immediately due and payable.

PATIENT SIGNATURE: ______________________________ DATE: ____ / ____ / ________

GUARDIAN'S SIGNATURE: ______________________________ RELATIONSHIP: ______________

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Please mark any allergies below:

Amoxicillin
Anesthesia
Animals
Aspirin/Pain Medicine
Bug Bites
Chlorine
Chocolates/Sweets
Codeine
Dairy Products
Dust
Eggs
Erythromycin
Fish
Gluten
Iodine
Lactose Intolerance
Latex
Morphine
Nuts
Oxycodone
Peanuts
Penicillin
Percocet
Ragweed/Pollen
Seasonal Allergies
Shellfish
Soaps
Sulfa
Tylenol
Vicodin
Other: ______________

Please mark any surgeries below:

Abdomen
ACL
Adnoids removed
Ankle
Appendix
Back
Bladder
Brain/Tumor
Breast
Carpal Tunnel
Circumcision
C-Section
Ear
Eyes
Foot
Gall Bladder
Gastric Bypass
Heart
Hernia
Hip
Hysterectomy
Knee
Neck
Nose
Oral
Shoulder
Sinus
Spleen
Tonsils removed
Tubal ligation
Vasectomy
Wisdom teeth
Wrist/Hand
Other: ______________

Please mark any past medical history conditions below:

Acid Reflux
Allergies
Ankle Pain
Anxiety
Arm Pain
Arthritis
Asthma
Back Pain
Bi-Polar Disorder
Broken Bones
Cancer
Carpal Tunnel Syndrome
Constipation
Depression
Diabetes
Difficulty Breathing
Dizziness
Ear Infections
Eczema
Elbow Pain
Endometriosis
Epilepsy
Eye/Vision Problems
Fatigue
Fibromyalgia
Foot Pain
Genetic Spinal Disorder
GERD
Hand Pain
Headaches
Hearing Problems
Heart Problems
Heartburn/Indigestion
High Blood Pressure
High Cholesterol
Hip Pain
Jaw Pain
Joint Stiffness
Kidney Stones
Knee Pain
Leg Pain
Low Back Pain
Lyme Disease
Menstrual Problems
Mid Back Pain
Multiple Sclerosis
Neck Pain
Neurological Disorder
Osteoarthritis
Osteoporosis
Pacemaker
Parkinson's Disease
Prostate Problems
Psoriasis
Sciatica
Scoliosis
Seizures
Shoulder Pain
Significant Weight Change
Spinal Cord Injury
Sprain/Strain
Stroke/Heart Attack
Thyroid Problems
Whiplash
Wrist Pain
Other: ______________

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DATE: _____ /_____ /________

CHILD'S NAME: ______________________________ CHART #: ____________

BIRTH WEIGHT: ____________________ BIRTH LENGTH: ____________________

PRESENT WEIGHT: ____________________ PRESENT LENGTH: ____________________

WAS THE BIRTH: Normal Vaginal Breech Vacuum Extraction Cesarean Forceps
Home Birth Hospital Birthing Center

PREGNANCY PROBLEMS: ______________________________

LABOR OR DELIVERY PROBLEMS: ______________________________ APGAR SCORES: ______

CONGENITAL DEFECTS/ANOMALIES: ______________________________

WAS THERE PRESENCE AT BIRTH: Meconium Cyanosis Jaundice

PEDIATRICIAN/FAMILY MD: ______________________________ DATE LAST EXAM: _____ /_____ /________

OSTETRICIAN/MID WIFE: ______________________________ DATE LAST EXAM: _____ /_____ /________

IMMUNIZATION DATES: Hep B _______ OPV _______ MMR _______ DTP_______ HIB_______ VAR_______

CHILDHOOD DISEASES: Measles Chicken Pox Whooping Cough Mumps Other: ____________

DATE AND PURPOSE OF LAST MD VISIT: ______________________________

HAS THIS CHILD BEEN TREATED FOR AN EMERGENCY? YES NO *If yes, please describe below:*

____

HAS THIS CHILD EVER SUFFERED FROM: (check any that apply)

Allergies	Diabetes	Neck Problems
Anemia	Diarrhea	Neuritis
Arm Problems	Digestion Problems	Orthopedic Problems
Arthritis	Dizziness	Paralysis
Asthma	Fainting	Poor Appetite
Backaches	"Growing Pains"	Rheumatic Fever
Bed Wetting	Headaches	Rupture/Hernias
Behavior Problems	Heart Trouble	Sinus Trouble
Broken Bones	Hyperactivity	Sugar Levels
Chronic Earaches	Hypertension	Tuberculosis
Cold/Flu	Joint Problems	Walking Problems
Constipation	Leg Problems	Other
Convulsions	Muscle Jerking	____________

DIET: ______________________________

ENVIRONMENTAL FACTORS: ______________________________

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FULL NAME: ____ CHART #: ______________

Please list any medications you are currently taking and why:

____
____
____
____

Please list any vitamins or supplements you are currently taking:

____
____
____

Please list any Family History Medical Conditions and Who they Relate to:
(Refer to Medical Conditions Above — Example: Mom: high blood pressure)

____
____
____
____

Is there anything else we should know about this child? Yes No *If yes, please describe below:*

____
____
____
____
____

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FULL NAME: ____ CHART #: ______________

What is your major complaint? ______________________________ Date problem began? ____ /____ /________

How did this problem begin (falling, lifting, etc.)? ____

How is the condition changing? Getting Better Getting Worse Not Changing

Has this condition exisgted in the past? Yes No

How often do they experience symptoms?

Constantly (76-100% of the day) Frequently (51-75% of the day)

Occasionally (26-50% of the day) Intermittently (0-25% of the day)

Describe the nature of the symptoms:

Sharp Dull Numb Burning Shooting Tingling Radiating Pain Tightness

Stabbing Throbbing Other: ____

Please rate the pain on a scale of 1 to 10 (0 = no pain and 10 = excruciating pain)

1 2 3 4 5 6 7 8 9 10

What makes your pain better (ice, heat, massage, etc)? ________________________________

What activities aggravate your condition (working, exercise, etc)? __________________________

PREVIOUS CHIROPRACTIC CARE?

Have you ever had chiropractic care? Yes No Where: __________________ When: ____ /____ /________

Why? ____

____

____

Were X-rays taken? Yes No When was your last adjustment: ____ /____ /________

SASSEVILLE
CHIROPRACTIC
WELLNESS CENTER

DATE: _____ / _____ / _______

CHART #: ________________

I, ____, give permission for my son/daughter to be treated at Sasseville Chiropractic Wellness Center without a parent/guardian present.

PATIENT NAME: ________________________________ DATE: _____ / _____ / _________

PARENT/GUARDIAN SIGNATURE: ____

RELATIONSHIP TO PATIENT: ____

SASSEVILLE
CHIROPRACTIC
WELLNESS CENTER

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DATE: _____ / _____ / _______

CHART #: _______________

Release Form for individuals involved in care of Patient

I, ______________________________, give SCWC permission to speak with the following people regarding my health status, including diagnosis, treatment options and plans and payment for health services I receive from SCWC. I also allow the following people to discuss information about my appointments.

This consent is valid until such time as I provide SCWC written revocation of it.

PATIENT NAME: ______________________________ DOB: __________

SCWC may speak with:

NAME: ____________________ DOB: __________ RELATIONSHIP: ____________

ADDRESS: ______________________________________

NAME: ____________________ DOB: __________ RELATIONSHIP: ____________

ADDRESS: ______________________________________

NAME: ____________________ DOB: __________ RELATIONSHIP: ____________

ADDRESS: ______________________________________

By signing this form, I authorize Sasseville Chiropractic Wellness Cetner to share my personal health information listed above to the person(s) or organization(s) I named on this form.
I understand that my personal health information may be shared by the person(s) or organization(s) and may no longer be protected by law.

PATIENT NAME: ______________________________ DATE: _____ / _____ / _______

PARENT/GUARDIAN SIGNATURE: ______________________________

RELATIONSHIP TO PATIENT: ______________________________

SASSEVILLE
CHIROPRACTIC
WELLNESS CENTER

PEDIATRIC INFORMATION

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PATIENT NAME: ____ CHART #: _____________

I do not wish to receive office notes for each of my chiropractic visits. I understand that by signing this document I am allowing Sasseville Chiropractic Wellness Center to omit asking if I need my office notes each time I come in.

I also understand that by signing this document that I will need to let Sasseville Chiropractic Wellness Center know if I need office notes for any future visits as they are available any time I need.

PATIENT/GUARDIAN SIGNATURE: ____

SCWC REPRESENTATIVE SIGNATURE: ____

SASSEVILLE
CHIROPRACTIC
WELLNESS CENTER

CHART #: ________________

HIPAA Omnibus Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

TREATMENT: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred, DME vendors, surgery centers/hospitals, referring physicians, family practitioner, physical therapists, home health providers, laboratories, worker comp adjusters and nurse case managers, etc to ensure that the healthcare provider has the necessary information to diagnose or treat you.

PAYMENT: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay, surgery, MRI or other diagnostic test, injection procedures, injection series, physical therapy, etc., may require that your relevant protected health information be disclosed to the health plan to obtain approval for the procedure.

HEALTHCARE OPERATIONS: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office.

In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.(this could be done by phone, email or mail). We use closed treatment rooms but you may still be in ear shot of other patients. Your initial and follow up evaluation notes will be sent to your Primary Care Physician.

If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in. We may disclose your health information to notify or assist in notifying a family member or another person responsible for your care about your medical condition or in the event of an emergency or of your death. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues and safety as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Mainecare Benefits. In the event that Sasseville Chiropractic Wellness Center is sold or merged with another organization, your health information/records will become the property of the new owner.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes. You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

CHART #: ________________

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information –This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications –You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

Changes to this Notice of Privacy Practices: we reserve the right to amend this Notice of Privacy Practices at any time in the future and will make the new provisions effective for all information that is maintains. Until such amendment is made, Sasseville Chiropractic Wellness Center is required by law to comply with this Notice. We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice, or if you want more information about your privacy rights, please contact us.

COMPLAINTS: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

Office Contact: Katrina Morin Phone: 207-777-3333 Email: katrina@sassevillechiropractic.com

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign below acknowledging your receipt of this notice.

PRINT FULL NAME	SIGNATURE	DATE ____ / ____ / ________

SASSEVILLE
CHIROPRACTIC
WELLNESS CENTER

CHART #: ______________

Cancellation / No Show Policy / Emergency Appointments

1. **Cancellation/No Show Policy for Appointments**

   We understand there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. Typically there are patients on a wait list for these services that could have been scheduled if given appropriate advanced notice.

   If an appointment is not cancelled at least 24 hours in advance, *you will be charged a $100 fee*; this will not be covered by your insurance company.

   After 3 no call no show/missed appointments in a row, the patient is released from active care.

2. **Scheduled Appointments**

   We understand that delays can happen, however, we must try to keep the other patients and doctors on time. We expect patients to arrive at least 5 minutes prior to their scheduled appointment.

   If a patient is 10 minutes past their scheduled time, we will have to reschedule the appointment. This will be considered a last minute cancellation and will result in a missed appointment, *you will be charged a $100 fee*; this will not be covered by your insurance company.

3. **After hours and Emergency Appointments**

   If the need arises for you to be seen by a SCWC provider outside of their normal SCWC hours, you will be charged an after-hours/emergency fee. "Outside of normal SCWC hours care" refers to any care provided by a provider that is scheduled outside of their typical schedule hours. Our office is closed every Thursday, weekends, and all major holidays.

   If you need emergency or after hours care, *there will be an additional $150 fee along with any service charges from your treatment*; this fee will not be covered by your insurance company.

PATIENT NAME PRINTED: ______________________________ DATE: ____ /____ /______

PATIENT SIGNATURE: ______________________________

CHART #: ________________

Billing Policy

Please be sure to contact your insurance company for specific benefit information. Although the chiropractor may participate with your insurance company, they may not be covered. *Some out-of-state policies do not reimburse for services provided by Doctors of Chiropractic (DC) since they do not credential them independently*.

- We will submit your claim for you. Co-payments are due at the time of service.
- Please direct any coverage, benefit or participation questions directly to your insurance company.
- Be sure to give your insurance company the name of the provider you will be seeing.
- ***Effective 9/19/2021 SCWC no longer participates in State of Maine Medicaid programs.***

Services denied as not covered by your insurance company are your responsibility.

We appreciate timely payment on patient statements. Payment in full is due on each statement. If payment in full can not be made, please contact our billing department at 777-3333 to discuss payment options. It is important to us that we work with you to ensure continuity of care.

Patient balances are payable within 30 days of original invoicing. If the patient account balance is still outstanding after 90 days, the account will be submitted to our collection agency.

- ***The patient will be responsible for any reasonable collection cost, including attorney fees if incurred.***

Who is responsible for this account? This should be the holder of the insurance plan. May we discuss your account with the Responsible Party listed below? (Please check one): YES NO

NAME OF RESPONSIBLE PARTY	SSN ___-___-___	RELATIONSHIP

ADDRESS / CITY / STATE / ZIP

It is your responsibility to keep us informed of any changes in your insurance coverage. Most plans have a filing limit, so any delay in the submission of claims may result in the denial of a claim. A delay caused by lack of information will be billable to you.

We accept cash, credits card, and personal checks.

I acknowledge awareness of the billing policies of Sasseville Chiropractic Wellness Center and agree to their terms. I agree to be financially responsible for services provided to me today and in the future at Sasseville Chiropractic Wellness Center.

PATIENT/RESPONSIBLE PARTY SIGNATURE

DATE ____ / ____ / ______

SASSEVILLE
CHIROPRACTIC
WELLNESS CENTER

CHART #: ________________

Payment Policy

Payments are expected at each appointment and can be paid via credit/debit card deductible. Please fill out the form below with credit/debit card information and choose the type of payments you authorize.

PATIENT NAME: ____

Please initial to Agree to:

______ Payment for copay or estimate cost per visit at each appointment.

______ Automatically pay any outstanding balances after claims process through Insurance.

I agree that Sasseville Chiropractic Wellness Center may charge my credit card on file for the balance due when they receive a copy of the EOB from my Health Insurance carrier. This authorization relates to all balances not covered by my insurance company for services provided by Sasseville Chiropractic Wellness Center. This could be amounts resulting from balances of copayment, deductible, co-insurance, non-covered or denials for no coverage, however is not limited to these scenarios.

I understand that this authorization is valid until such time as I provide a 30-day written notice to cancel the authorization. Written notice must be submitted to the address below for processing.

CHECK ONE: MASTERCARD VISA AMEX DISCOVER

CREDIT CARD #: ______________________________ EXP. DATE: ____ / ____ / ______

PRINTED NAME ON CARD: ______________________________________

PATIENT SIGNATURE: ______________________________ DATE: ____ / ____ / ______

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Non-Medicare Advanced Beneficiary Notice (ABN)

PATIENT NAME: ____________________ DOB: __________ CHART #: ______________

Your insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need.

Services below may NOT be payable by your medical plans and would need to be Paid At Time of Service.

Appropriate copays need to be ***paid at time of service***.

Items below list the estimated cost that will be billed to your insurance company. Any of these services provided that do not get paid by your insurance, will be considered ***Patient Responsibility***.

TREATMENT	EST. COST
Acupuncture	Up to $400
After hours/emergency care	$150
Consultations	Up to $175
Distraction	$30
Kinesiotape/Posture Rehab/Tex	$55
MT/NMR Therapy	$110-$210
Muscle Stimulation Therapies	Up to $50

TREATMENT	EST. COST
New Patient Exam	Up to $350
Orthotics	$85-$500
Re-evaluations	Up to $250
Spinal Adjustments	$55-$125
Extra Spinal Adjustment	$50
Wellness Care	Up to $500
X-rays	$80-$150

WHAT YOU NEED TO DO NOW

- Read this notice, so you can make an informed decision about your care
- Ask us any questions that you may have after you finish reading
- Please draw a line through any service you DO NOT want performed

Additional information: If you have a managed care plan (HMO), you will need a referral from your primary care provider (PCP). Any unpaid services are your financial responsibility.

Signing below means that you have received and you understand this notice.

PATIENT SIGNATURE: ______________________________ DATE: _____ /_____ /_________

CHART #: ________________

Dear Patient:

We are always happy to submit a claim to your insurance company for services rendered. However, your insurance company may not cover any service, unless you obtain a referral from your Primary Care Physician. (Please consult your member handbook regarding referrals from your Primary Care Physician)

It is your responsibility to obtain a referral. Your signature below indicates that if you receive specialty care without consent of your Primary Care Physician, you will assume financial responsibility.

Thank you.

PATIENT NAME: ____ DATE: ____ / ____ / ________

PATIENT/GUARDIAN SIGNATURE: ____

SCWC REPRESENTATIVE SIGNATURE: ____