CLIENT REGISTRATION

You have my permission to leave phone messages and send mail to:

Client Name:_____ Birthdate:_____ Age: _____

Address:_____
Street City State Zip

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

Marital Status: _____ Social Security #: _____

Employer: _____

Referred By: _____

You have my permission to contact the following person:

_____
Name Relationship to Client

_____
Address Phone

INSURANCE INFORMATION

Insurance Carrier: _____ Group #:_____

Name of Card Holder: _____ Age: _____ DOB: _____

Address: _____
Street City State Zip

Relationship to Client: _____ Insurance ID #: _____

RESPONSIBILITY FOR PAYMENT

I understand that all services are rendered and charged to me and not to an insurance company. I understand that I am responsible for paying for all services and charges that are not covered by my insurance, including telephone calls, preparation of reports, and any unkept appointments. I understand that I am responsible for paying full charges on all appointments that are unkept, rescheduled, or canceled with less than twenty-four (24) hours' advance notice to Dr. Doverspike.

I understand and agree that I will pay all fees at the time services are rendered or billed to me. I understand that Dr. Doverspike cannot accept responsibility for collecting or negotiating a settlement on a disputed claim. I hereby accept full and complete responsibility for all debts and obligations during the course of the above-named client's evaluation and/or treatment. For the purpose of collecting debts, I understand and agree that the above information will be released to Nations Recovery Center (NRC) or other collection agency in the event that I do not pay my account within thirty (30) days of services being rendered. I authorize the above information, including last date of service and total amount of debt, for the purpose of collecting the debt.

_____ _____

Name Date