Dr. Frank Watson, D.C.
FIT Chiropractic & Acupuncture
Phone 850.661.8848 Fax 850.273.7806

Patient Information

Name:_____ DOB: _____ Gender_____

Address:_____ City, State, Zip: _____

Phone (H) _____ (C)_____(W) _____

Email: _____

Emergency Contact:_____ Relationship:_____ Phone:_____
Referring Doctor: _____ Phone: _____

Primary Care Doctor: _____ Phone: _____

Insurance Information

(If visit is related to an automobile accident, please provide **YOUR** vehicle insurance information)

Primary Insured: _____Relation: _____ DOB:_____
Insurance Provider: _____Phone: _____
Address: _____
Policy # _____ Group # _____
Claim #(if Applicable)_____
Effective Date: _____ Exp. Date _____

Please note we are currently In-Network for United, VACCN, & FL Blue
Acupuncture/Dry Needling Services Rarely Covered

Patient/Guardian Signature: _____
Date: _____
Patient Print Name: _____
Guardian(if minor) Print Name: _____

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PATIENT CONSENT

CONSENT FOR TREATMENT: I voluntarily consent to the rendering of care, including the treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician, and it is
the responsibility of the staff to carry out the instructions of such physician(s)

PAYMENT POLICY: I understand and agree that my insurance policy is and arrangement between myself and my insurance carrier. I understand and agree that I am personally responsible for payment of all services rendered to me, and minor if applicable.

MISSED APPOINTMENTS: We understand things come up from time to time that may prevent you from keeping your appointment. We ask that you give us 24 hours notice so that we may offer this time to another patient. Missed appointments without notice may be charged a fee of $25. These charges are your responsibility and will be billed directly to you. Please help us to serve you better by keeping your scheduled appointment.

RELEASE OF INFORMATION: By signing this form, you are granting consent to Frank Watson, D.C., LAC to use and disclose your protected health information for the purpose of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notices of Privacy Practices before you sign this consent, and we encourage you to read it in full. Our Notice of Privacy Practices is subject to change. If we change our notice, you maybe obtain a copy -of the revised notice by telephoning our office at 850-661-8848 or by email info@drfrankwatson.com You have a right to request us to restrict how we use and disclose your protected health information for the purpose of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Print Patient Name: _____ Date: _____

Patient Signature: _____

Parent/Guardian(if patient is a minor): _____

DOB:_____

VERIFICATION OF NON-PREGNANCY (FEMALE PATIENTS ONLY):
By Initialing on this form, I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this time.

Date of last menstrual cycle: _____ Patient Initial: _____

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Medical Record Request

Date: _____

Fax:_____

Attention: _____

Patient, _____, requests release of Medical Records to FIT Chiropractic & Acupuncture.

- Daily Encounters
- Exam Findings
- Imaging; with any Physician notations

Patient Name (Print) _____

Patient D.O.B. _____

Patient Signature _____ Date: _____

4455 N 9th Ave, Pensacola, FL 32503
www.DrFrankWatson.com