Name: _____ Today's Date: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Mobile Phone: _____
E-Mail Address: _____
Date of Birth: _____ Age: _____ Sex: _____
Marital Status: _____

Employer: _____ Occupation: _____
Address: _____
City: _____ State: _____ Zip: _____
Work Phone: _____

Spouse: _____ Mobile Phone: _____
Employer: _____ Address: _____
City: _____ State: _____ Zip: _____

Whom may we thank for referring you? _____

Circle Method of Payment: ***Cash*** Check *Credit/Debit* *Auto* ***Workers Comp.***

We are providers for Medicare and Blue Cross Blue Shield PPO **ONLY**.
Insurance Company: _____ Phone Number: _____
Member ID/Claim Number: _____

What do you want out of your healthcare experience?

____ **Relief Care** (Patch the problem, temporarily)
____ **Corrective Care** (Fix the problem)

Our Vision

THORASSIC PARK was created to offer the ultimate healthcare experience to everyone who enters our doors. We believe that just because a person is hurting, going to the doctor shouldn't be a painful experience. We want you to be completely satisfied with our care and will do everything in our power to see that you get what you want effectively and promptly. We want to give you the confidence to invite your family, friends and co-workers to enjoy the benefits of 21st century healthcare. Enjoy your adventure.

Dr. Lee Rangel, DC
Park Ranger

Assignment of Benefits

I, _____, hereby authorize the insurance company/carrier/insurer providing applicable insurance coverage to make medical benefit payments, otherwise payable to me for services rendered by THORASSIC PARK, but not to exceed the charges of those services, payable to and mailed directly to: THORASSIC PARK, 1603 60th Avenue West Bradenton, Florida 34207.

Furthermore, I hereby assign to THORASSIC PARK, the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and/or charges provided by THORASSIC PARK. I understand that I am transferring to THORASSIC PARK the rights to my insurance benefits, and other payment sources listed above, as they become due for services provided, as well as the right to file and maintain a lawsuit against the insurance company or other responsible party in order to collect such insurance benefits or other payments.

I authorize THORASSIC PARK to release any information to my insurance carrier or attorney that will assist in payment of my claims. This office is authorized to act as attorney-in-fact to correspond, on my behalf, with insurance companies to negotiate settlement of medical payment. I fully understand and agree that an insurance policy is an arrangement between the insurance carrier and negligent parties, as well as any legal fees incurred to collect any unpaid balance.

Medical Release

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services or supplies pertaining to me to release true copies of same to THORASSIC PARK or any insurer providing coverage to me. In connection with the processing of any claim for benefits made by me or by the assignee herein. A photocopy of this document shall be as binding as an original signature page.

Authorization for Treatment and Consent for Care

I understand and agree that I am personally responsible for payment of all services rendered. Health and accident policies are an arrangement between an insurance carrier and myself, however, THORASSIC PARK may accept certain insurance assignments of benefits. I understand and agree that I am ultimately responsible for any payment that my insurance carrier or any third party payer does not pay. The acceptance of insurance is individually determined and prior authorization is requited. I understand that upon termination of care, any outstanding charges for professional services rendered will be immediately due and payable. Furthermore, I hereby voluntarily consent to examination, diagnostic treatment and/or chiropractic care by THORASSIC PARK, its physicians and employees as explained to me by attending physician and whomever he/she may designate as their assistant. I am aware that chiropractic/medicine is not an exact science and that any procedure has an inherent risk. I acknowledge that no guarantees have been made to me as a result of any treatment or examination in this office.

BY MY SIGNATURE BELOW, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THIS DOCUMENT.

_____ _____

Signature Date

Consent to treat minor child (Print Minor's Name): _____

Parent and/or Guardian Signature & Relationship: _____

Acknowledgment of Receipt
Of
Notice Of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

Patient Name (Please Print) Date

_____ _____

Parent, Guardian or Patient's legal representative Date

_____

Signature

This form will be placed in the Patient's chart and maintained for six years.

Massage Cancellation Policy

We sincerely appreciate having you as a massage patient at Thorassic Park. We strive to provide you with the best service possible AND do our best to keep massage therapists on staff to handle your massage needs.

Because of the limited number of massage therapists for our many massage patients, we have implemented a massage cancellation policy for missed massage appointments.

Please give our office at least 24 hours notice if you MUST cancel your appointment, otherwise we will charge:

$15.00 fee for missed half hour massage.

$30.00 fee for missed one hour massage.

$45.00 fee for missed one and a half hour massage.

$60.00 fee for missed two hour massage.

I _____ have read and understand the massage cancellation policy.

Patient's Signature: _____ Date: _____

Thank you for your understanding in this matter.

Dr. Lee Rangel, DC and staff.