Name:______________________________ Date of Birth: __________________________

Patient Information

Date___________

Patient_________________________________

Address_________________________________

____

____

Email___________________________________

Sex: M F Age_____ **Birthdate**___________

Patient SS#______________________________

Occupation______________________________

Employer____________ **Phone**______________

Employer Address________________________

Employer Phone_________________________

Spouse's Name__________________________

Whom may we thank for referring you?_________________________________

Insurance

Insurance Company_________________

Claim #______________

Adjuster Name__________________________

Phone___________________ **Ex**_____________

Health Insurance_________________________

ID #___________________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with the listed above and assign directly to Pure Life Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____

Responsible Party Signature

____

Date

Phone Numbers

Home________________ **Cell**________________

IN CASE OF EMERGENCY, CONTACT:

Name________________ **Relationship**_______

Home Phone_________________

Work Phone__________________

Accident Information

Is condition due to accident: YES NO

Date of accident_____________ **State**______

Type of accident: AUTO WORK HOME

To whom have you made a report of your accident?________________

Name:____________________________

Date of Birth: ________________________

Pure Life Clinic Consent Form

Chiropractic examination and therapeutic procedures (including chiropractic manipulation, hot and cold applications, frequency specific microcurrent, electrotherapy, taping and bracing, and manual muscle therapy, etc.) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. These complications may include, but are not limited to: soreness, inflammation, soft tissue injury, dizziness, burns, temporary worsening of symptoms. More serious complications are extremely rare, such as disc herniations and strokes. Additional information on side effects and complications is available upon request. It is also our policy to inform you of the procedure being performed and the risks and alternative treatments available. If your physician does not explain to your satisfaction, please ask for more information.

I have read, understand, and have no further questions regarding the above statements concerning treatment side effects and risks, and I also understand that there is no guarantee for a specific cure or result. I understand both my rights and responsibilities in this doctor/patient relationship.

____Date_______________________
Patient Signature or Guardian if patient is under 18 years of age

____
Print Name

Name:______________________________ Date of Birth: __________________________

Patient History and Condition

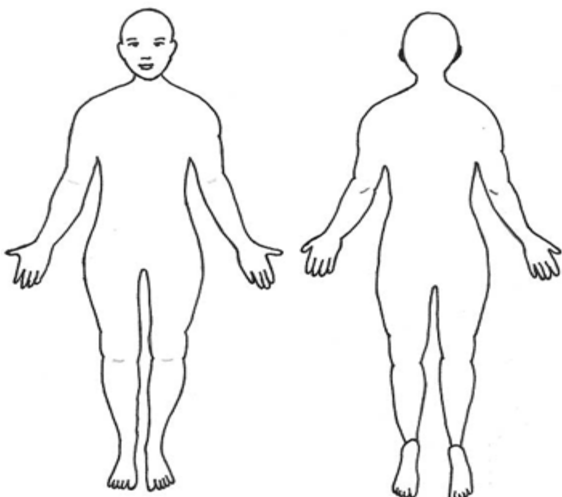
Reasons for Visit

Describe the conditions/symptoms you are currently experiencing:

- Concern #1:____
- Concern #2:____
- Concern #3:____

	Condition #1	Condition #2	Condition #3
When did these symptoms begin?	______________	______________	______________
Is the condition getting progressively worse?	______________	______________	______________
Rate the severity of your pain from 1 to 10	______________	______________	______________
How often do you experience these symptoms?	______________	______________	______________
Is the pain constant or varied in duration?	______________	______________	______________
Describe the pain using words below	______________	______________	______________
(Sharp/Dull, Throbbing, Aching, Shooting,	______________	______________	______________
Burning, Cramps, Stiffness, Swelling)	______________	______________	______________
Does the pain interfere with your….			
Work?	______________	______________	______________
Sleep?	______________	______________	______________
Daily Routine?	______________	______________	______________
Recreation?	______________	______________	______________
Does it cause numbness, tingling, or weakness?	______________	______________	______________
What treatment/therapy have you tried?	______________	______________	______________
Have you experienced this condition previously?	______________	______________	______________
If yes, when did you previously experience it?	______________	______________	______________
Has the issue resolved previously?	______________	______________	______________

Mark an X on the picture where you continue to experience symptoms.



List activities that are painful, such as sitting, standing, etc:

____

____

____

For Women Only -

Are you pregnant: _________ if yes, Due date: __________

Do you have children: _______ if yes, list ages: ___________

Name:______________________________ Date of Birth: __________________________

Health History

What treatment you have already received for your condition? (circle all that apply)

Chiropractic Massage Acupuncture Medications Physical Therapy Surgery None

Date of Last: Physical Exam:_________________ Spinal X-ray: ______________ Blood Test: __________________

Spinal Exam: __________________ Chest X-ray: ______________ Urine Test: ___________________

Dental X-ray: __________________ MRI, CT-Scan, Bone Scan: _________________________________

Please circle to indicate if you have had any of the following:

AIDS/HIV	Diabetes	Measles	Rheumatic fever
Alcoholism	Emphysema	Migraine Headaches	Scarlet fever
Allergy Shots	Epilepsy	Miscarriage	Stroke
Anemia	Fractures	Mononucleosis	Suicide attempt
Anorexia	Glaucoma	Multiple Sclerosis	Thyroid Problems
Appendicitis	Goiter	Mumps	Tonsilitis
Arthritis	Gonorrhea	Osteoporosis	Tuberculosis
Asthma	Gout	Pacemaker	Tumors, growths
Bleeding Disorders	Heart Disease	Parkinson's disease	Typhoid Fever
Breast Lump	Hepatitis	Pinched Nerve	Ulcers
Bronchitis	Hernia	Pneumonia	Vaginal Infections
Bulimia	Herniated Disk	Polio	Venereal Disease
Cancer	Herpes	Prostate problem	Whooping Cough
Cataracts	High Cholesterol	Prosthesis	Other:____________
Chemical Dependency	Kidney Disease	Psychiatric care	
Chicken Pox	Liver Disease	Rheumatoid arthritis	

Lifestyle Habits – please circle the choices that apply

Exercise	**Work Activity**	**Habits**	
None	Sitting	Smoking	Packs/Day: _________
Moderate	Standing	Alcohol	Drinks/Week: _______
Daily	Light Labor	Coffee/Caffeine	Cups/Day: __________
Heavy	Heavy Labor	High Stress LevelReason: ____________	

List the following	**Description**	**Date**
Falls	______________________________	______________
Head injuries	______________________________	______________
Broken bones	______________________________	______________
Dislocations	______________________________	______________
Surgeries	______________________________	______________

Medications	**Allergies**	**Vitamins/Herbs/Minerals**
________________	________________	______________________
________________	________________	______________________
________________	________________	______________________
________________	________________	______________________

Name:______________________________ PURE LIFE CLINIC Date of Birth: __________________________

Health History Continued

General Health Questions

(if the answer to any question is yes, please provide additional details/explanation)

Do you commonly experience headaches or dizziness? ____

Do you typically have high or low blood pressure? ____

Have you had any recent bowel or bladder changes? ____

Have you had any recent significant weight loss or gain? ____

Have you recently experienced "sweats" or "chills"? ____

Have you recently experienced significant fatigue? ____

Do you have a family history of any medical conditions?

Medical Condition	Relationship to you	Living or Deceased	Age

--------------------------------Doctor's Notes------------------------------------

Name:_____________________________ Date of Birth: _________________________

Worker's Compensation Injury Questionnaire

PLEASE PRINT

Name:____ Today's Date:__________________________

Employer's Business Name where accident occurred:____

Employer's Phone Number:________________________ Occupation:____

Employer's Address:____

Length of time at this job prior to injury:________________________ Last Date worked:_____________________

Date of Injury:__________________________ Time of Injury:___________________________

Please explain what you were doing at the time you were injured and how the accident happened (lifting, bending, walking, carrying, standing, etc.)____

____

____

When did the pain begin? (Be specific):____

Where did you first feel the pain? (Be Specific):____

Was the pain intense at first or did it gradually worsen?:____

SYMPTOMS FROM ACCIDENT

Did you experience bleeding cuts or bruises? ☐ Yes ☐ No
Location of bleeding cuts:________________________ Location of Bruises: __________________________________

Please describe how you felt immediately after the accident. (Please be specific):___________________________

____

Please describe how you felt later that ☐ Day ☐ Night:____

Check the symptoms that have become apparent since the accident/injury:

- ❑Nervousness
- ❑Neck Pain/Stiffness
- ❑Mid back Pain
- ❑Low Back Pain
- ❑Eyes sensitive to light
- ❑Pain behind eyes
- ❑Dizziness
- ❑Cold sweats
- ❑Face flushed
- ❑Ringing/Buzzing ears
- ❑Fever
- ❑Loss of balance
- ❑Loss of smell
- ❑Loss of taste
- ❑Loss of memory
- ❑Pins & Needles – Arms
- ❑Pins & Needles - Legs
- ❑Shortness of breath
- ❑Head seems too heavy
- ❑Irritability
- ❑Depression
- ❑Other_______________
- ❑Sleeping trouble
- ❑Toe Numbness
- ❑Finger Numbness
- ❑Cold Hands
- ❑Cold Feet
- ❑Chest Pain
- ❑Constipation
- ❑Diarrhea
- ❑Fatigue
- ❑Tension
- ❑Headache
- ❑Fainting
- ❑Anxiety
- ❑Seizures
- ❑Visual disturbance
- ❑Forgetfulness
- ❑Blurred Vision
- ❑Double Vision
- ❑Confused
- ❑Disoriented

Name:______________________________ Date of Birth: __________________________

MECHANISM OF INJURY

Please explain the mechanism of the injury (only fill in those sections that apply to you):

A.) Fall? ❑Yes ❑No (If no, move to letter B)

- Did you hit anything when you fell? ❑Yes ❑No If yes, what?___________________________________
- Were you carrying anything when you fell? ❑Yes ❑No If yes, what?_____________________________
  How much did it weigh? ______________lbs
- Did you twist when you fell? ❑Yes ❑No If yes, to which side?____________________
- Was the area lighted? ❑Yes ❑No

Describe the condition of the area (slippery, graveled, etc.) ______________________________________

What part of your body did you fall on? ____

How far did you fall? __________________feet.

What did you land on? ____

B.) Lift/Pull: ❑Yes ❑No (If no, move to letter C)

- How much did the object weigh? ___________________________lbs.
- Did you fall after the injury? ❑Yes ❑No If yes, how far? ____________________________________
- Did you hit anything when you fell? ❑Yes ❑No If yes, what?
  ____
- Were you twisting when you were lifting/pulling? ❑Yes ❑No If yes, to which side? ❑Left ❑Right
- How far off the ground did you have the object before it the pain started? _________________________
- Did you drop the object when the pain started? ❑Yes ❑No
- Did it land on you? ❑Yes ❑No If yes, where?
  ____
- Did you lift with your: ❑Legs ❑Back ❑Other:
  ____

C.) Bend: ❑Yes ❑No

- Were you lifting when you bent over? ❑Yes ❑No If yes, how much did the object weigh?

Name:_____________________________ Date of Birth: _________________________

_______________lbs

- How far were you bent over? ____
- Did you fall when the pain started? ❑Yes ❑No If yes, how far? ______________________________
- Were you twisting when you bent forward? ❑Yes ❑No
  Toward which side? ❑Right ❑Left
- Did you land on anything? ❑Yes ❑No
  If so, what? ____

WORK STATUS HISTORY

- Have you lost time off from work as a result of this new injury? ❑Yes ❑No
  If yes, please give dates:____
- Have you gone back to work? ❑Yes ❑No When?____
  If yes, what is the status? ❑Modified ❑Regular

  If modified work status, list restrictions you have been placed on:___________________________
  ____

  If you have gone back to work, list the activities that are:
  PAINFUL:____

  DIFFICULT:____

FIRST DOCTOR/HOSPITAL/CLINIC

- Were you hospitalized as a result of this accident? ❑Yes ❑No
  If yes, where?____________________________________
- Did you visit a clinic/Doctor? ❑Yes ❑No

Doctor 1 name:____ Date of first visit:______________________

- Were you examined? ❑Yes ❑No Were X-Rays taken? ❑Yes ❑No
- What diagnosis did the doctor give you? ____
- Were you given treatment? ❑Yes ❑No
  If yes, what type?____

  What benefits did you receive from this treatment?_______________________________________
  ____

  Date of last treatment?____
- Did the doctor refer you to another health professional? ❑Yes ❑No
  If yes, to whom and for what?____

Name:______________________________ Date of Birth: __________________________

- Did you follow the doctor's recommendation? ❑Yes ❑No
  If no, why not?____

SECOND DOCTOR/HOSPITAL/CLINIC

Doctor 1 name:____ Date of first visit:_________________________

- Were you examined? ❑Yes ❑No Were X-Rays taken? ❑Yes ❑No
- What diagnosis did the doctor give you? ____
- Were you given treatment? ❑Yes ❑No
  If yes, what type?____

  What benefits did you receive from this treatment?____
  ____

  Date of last treatment?____

PRIOR SIMILAR SYMPTOMS

- Did you have any physical complaints just before the accident? ❑ Yes ❑ No
  If yes, please describe in detail:____
  ____
- Have you ever had any prior injuries, accidents, diseases, or treatment to the area of your body now affected?
  ❑ Yes ❑ No
  If yes, what part was previously injured? ____

  Date of previous injury:___________________________

  Describe previous injury:______________________________
- Were you treated? ❑ Yes ❑ No
  By whom? ____

  Date treatment began:______________________________ Date treatment ended:__________________

  Date you last had complications or pain from that previous injury:_______________________________

JOB DESCRIPTION

In terms of an 8 hour work day: ***Occasionally*** = 1 - 33%, ***Frequently*** = 34% -66%, ***Continuously*** = 67% - 100%

In a typical 8 hour work day, I (write the number of hours (1-8) you do the following activities):

Sit: __________ hours Stand: _____________hours Walk: __________ hours

On the job, I perform the following activities:

Name:______________________________ Date of Birth: __________________________

	Not at all	Occasionally	Frequently	Continuously
Bend/Stoop	❑	❑	❑	❑
Squat	❑	❑	❑	❑
Crawl	❑	❑	❑	❑
Climb	❑	❑	❑	❑
Reach Above	❑	❑	❑	❑
Shoulder Level	❑	❑	❑	❑
Crouch	❑	❑	❑	❑
Kneel	❑	❑	❑	❑
Balancing	❑	❑	❑	❑
Pulling/Pushing	❑	❑	❑	❑

On the job, I lift:

	Not at all	Occasionally	Frequently	Continuously
Up to 10 pounds	❑	❑	❑	❑
11 to 24 pounds	❑	❑	❑	❑
25 to 34 pounds	❑	❑	❑	❑
35 to 50 pounds	❑	❑	❑	❑
51 to 74 pounds	❑	❑	❑	❑
75 to 100 pounds	❑	❑	❑	❑

❑Yes ❑No Are you required to bend over while doing any lifting?
❑Yes ❑No Are your feet used in repetitive movements, such as operating foot controls?
❑Yes ❑ No Are your hands used in repetitive movements, such as operating foot controls?

❑Yes ❑ No Are you required to work at unprotected heights?
If Yes, Please describe:____

❑Yes ❑ No Are you required to be around machinery?
If yes, Please describe:____

❑Yes ❑ No Are you exposed to marked changes in temperature and humidity?
If yes, Please describe:____

❑Yes ❑ No Are you required to drive automotive equipment?
If yes, Please describe:____

❑Yes ❑ No Are you exposed to dust, flames. And/or gases?
If yes, Please describe:____

Please list any additional comments:-

____
____
____
____

Patient Signature:____ **Date:**____________________

Name:____________________________ Date of Birth: ________________________

Pure Life Clinic 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 takes effect on February 1st, 2007 and remains in effect until we replace it.

1. OUR PLEDGE REGARDING YOUR MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our clinic. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law requires us to:

1. Keep your medical information private.
2. Follow the terms of the notice that is now in effect.
3. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.

We have the right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information we keep, including information previously created or received before the changes.

Notice of change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes.

FOR HEALTHCARE OPTIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality of care, evaluation of the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to better

serve you.

4. ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment and healthcare operations, we may use and disclose medical information for the following purposes.

Facility Directory: Unless you notify us that you object, the following medical information about you will be placed in our facilities' directories: your name; your location and contact information; your condition described in general terms. We may use these listings when sending out information to our patients.

Notification: Medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition or death. If you are present, we will get you permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for you health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief: Medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Research in Limited Circumstances: Medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner: To help them carry our their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court of administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances such as a court order, warrant, or grand jury subpoena, a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim, or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official of correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with prevention or controlling disease, injury or disability including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems to enable product recalls, repairs, or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk if contracting or spreading a disease or condition.

Victims of Abuse, Neglect or Domestic Violence: We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or

safety or the health or safety of others. We may share medical information when necessary to help law enforcement official capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises and crimes in emergencies.

5. YOUR INDIVIDUAL RIGHTS

You Have a Right to:

1. Look at or get copies of your medical information, you may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. If you request copies, we will charge you $2 for each page, and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and healthcare operations and other specified exceptions.
3. Request that we place additional restriction on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to one of the contacts listed at the end of this notice.
5. Request that we change you medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed, If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing the Privacy Officer at our office.

Questions and Complaints

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

****

I have read and understand the contents of this document.

Print name: ____

Name:______________________________ Date of Birth: __________________________

Signature: ____ Date: __________

Signature of Legal Guardian (if patient under 18): ____

Pure Life Clinic Financial Policy

118 N. Killingsworth St. Portland, OR 97217 503.288.4454

Cost of Services

All health insurance and personal injury protection PIP rates are billed according to the Oregon Workers' Compensation Fee Schedule. The state of Oregon determines these fees every second April. Visit the Oregon.gov website to better understand how health insurance works in Oregon.

Pure Life Clinic is pleased to offer a time of service discount. A Time of Service Discount is a discount off of our standard fee schedule. This discount is available to any and all patients making full payment at time of service. Payment can be made via check, cash, or credit card. By eliminating the many administrative costs and tasks that must be completed when processing insurance claims, we are able to pass the savings onto our patients that have no coverage.

Insurance

We strongly advise you to contact your insurance company to discuss your benefit coverage for chiropractic, massage and other therapeutic services as coverage for these can vary greatly. As a courtesy we can verify the benefits on your plan. However, this is not a guarantee of coverage for the services provided. Your insurance company may require that you pre-certify or register your treatment with us prior to your visit. It is your responsibility to monitor insurance benefits, deductibles, pre-certifications, re-certifications, annual benefit maximums, primary care physician notification, effective date and termination dates of coverage. If your insurer denies payment for services, payment will be your responsibility.

We are participating providers for most health insurances; however, it is your responsibility to make sure the provider that you are scheduled with is participating in the network.

This office requires that you pay your co-pays and any deductibles required at each appointment.

Patient Responsibility

As mentioned above, it is the patient's responsibility for any co-payments, coinsurance, deductible and non-covered services. This office reserves the right to refer out to collections, any account we deem delinquent with one prior notice to the patient. Payment arrangements should be made prior to the account being referred to our collections department.

Confidentiality

Your records or information about your case cannot be shared without your prior written permission, and your records will not be released without written approval of the patient or the responsible party of a minor.

Missed Appointments

We require at least 24 hours notice if you need to change or cancel your appointment. If you fail to keep your appointment or do not provide us with 24 hours notice, you will be charged a $40 "broken appointment fee". This fee is the same for all patients regardless of insurance coverage. Broken appointment fees must be paid prior to rescheduling your appointment. Broken appointment fees also cannot be billed to your insurance carrier and are solely the responsibility of the patient.

I have read, understand, and agree with the preceding described financial policies. By signing I agree that I also understand that as the patient or legal guardian of the patient, I am ultimately personally responsible for any and all costs associated with the course of my treatment and care at Pure Life Clinic.

Signature____ Date_________________

Name:______________________________

Date of Birth: __________________________