

Shari Ough, DC
Albany Hill Health Center
514 Kains Ave., Albany, CA 94706
510-527-7443

Patient Information

Name _____ Date _____
Address _____ City _____ State _____ Zip _____
E-mail _____ Phone : H/ _____ W/ _____ Cell/ _____
Age _____ Birth date _____ Sex M / F Status M / S / D / W No. of Children _____
Occupation _____ Employer _____ City _____
Spouse's Name _____
Primary Medical Physician _____ Date of last exam _____
Have you received chiropractic care before? Y / N Name of chiropractor _____
Referred by _____

Office Policy and Financial Agreement

All fees are due and payable at the time of your office visit.

If you have insurance: As a courtesy, we will generate an insurance claim form for you at the time of your visit or at the end of the week (if multiple visits exist for that week). You will then need to put it in the mail to your insurance company; this insures prompt repayment to you.

Please supply us with your insurance card and we will verify chiropractic coverage under your policy. We know that insurance companies can be challenging and we are prepared to help you with your claim.

Insurance Information *If applicable

**Please notify the front desk for special insurance processing.*

Social Security # _____
Insurance name _____
Subscriber name _____ Relationship _____
Address _____ City _____ State _____ Zip _____
Subscriber # _____ Group # _____
Deductible \$ _____

Missed Appointments / No Show Policy: In order to better serve all of our patients, we require and appreciate a **24-hour cancellation notice** or you will be charged for the scheduled appointment time. Thank you for your cooperation on this matter.

Your health needs are our chief interest and concern; we appreciate you choosing Dr. Shari Ough.

Your signature indicates these statements have been read and understood.

Signature of patient or guardian

Date