

(PLEASE CIRCLE APPROPRIATE RESPONSE) THIS IS A NEW / OLD INJURY / ILLNESS. IT WAS / WAS NOT TREATED BEFORE. IF TREATED BEFORE, WHAT WAS DONE? _____

NAME OF DOCTOR: _____ DATE OF LAST VISIT: _____

LIST DATES OF ANY SURGERIES OR HOSPITALIZATIONS: _____

LAST TIME YOU HAD X-RAYS: _____

LIST ANY MEDICATIONS YOU ARE CURRENTLY ON: _____

(FROM BIRTH TO PRESENT) LIST ANY CAR ACCIDENTS WITH DESCRIPTIONS AND DATES: _____

LIST FALLS/INJURIES: _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for the payment. I understand I am responsible for deductibles and co-payments. I authorize JAMES AYLOR, D.C. to examine, take x-rays, and treat me in accordance with the state statutes for the care and management of my condition. I also understand that if I suspend care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient Signature: _____ Date: _____

I hereby authorize the JAMES AYLOR, D.C. to administer treatment as necessary.

Guardian authorizing treatment: _____ Date: _____

Assignment & Instruction for direct payment to doctor for private and group accident/health insurance.

I hereby instruct and direct the _____ insurance company to pay by check, made out to Camarillo JAMES AYLOR, D.C. and mailed directly to: JAMES AYLOR, D.C., 1200 PASEO CAMARILLO STE. #160, CAMARILLO, CA 93010. If my current policy prohibits direct payments to doctor, then I hereby also instruct and dire you to make the check payable to me and mail it as follows: c/o JAMES AYLOR, D.C., 1200 PASEO CAMARILLO STE. #160, CAMARILLO, CA 93010. The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay in a current manner any balance of said professional service charges over and above this insurance payment. A photocopy of this Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

SIGNATURE OF POLICYHOLDER: _____ DATE: _____

SIGNATURE OF CLAIMANT, IF OTHER THAN POLICYHOLDER: _____ DATE: _____

AUTHORIZATION TO RELEASE X-RAYS & MEDICAL INFORMATION

I _____ REQUEST THE FOLLOWING INFORMATION:

RECORDS X-RAYS REPORTS OTHER

TO BE RELEASED TO: _____

FOR THE PURPOSE OF: REVIEW EVALUATION INSURANCE CLAIMS PROCESSING
 OR ANY PURPOSE REASONABLY RELATED TO THE ABOVE

I UNDERSTAND THAT I HAVE A RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION UPON MY REQUEST. A PHOTOCOPY OF THIS RELEASE SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

SIGNED: _____

PATIENT SPOUSE PARENT GUARDIAN

JAMES AYLOR, D.C., 1200 PASEO CAMARILLO STE. #160, CAMARILLO, CA 93010 (805) 987-1800