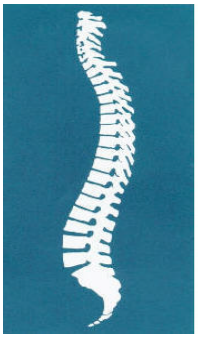

Greathouse Chiropractic & Rehabilitation Services

JAMES E. GREATHOUSE JR., BS, DC, DACRB
1589 S. WICKHAM RD., W. MELBOURNE, FL. 32904
321 725-6314 FAX 724-1533

Name _____ Age_____ Date of Birth _____ Male __Female __

Permanent Address _____

Temporary Address _____

SS# _____Marital Status _____Primary Care Provider _____

Home Phone # _____ Work # _____ Referral Source _____

Occupation _____ Employer_____

Insurance Information _____

Circle One Work Related Injury - Motor Vehicle Accident - Home Injury - Sports Injury - Other

Consent for Doctor to Proceed with Treatment
I understand that if Dr. Greathouse accepts me as a patient, I am authorizing him to proceed with treatment. Any risks regarding care will be explained to me upon request.

*** Patient / Guardian Signature** _____ **Date** _____

Please Read and Sign

I authorize the doctor to release to my insurance carrier, employer, attending physician any information needed, including diagnosis and records of any treatment or exam rendered to me to process this claim or manage my condition.

I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for services rendered by Dr. Greathouse or services under the auspices of his care, to Dr. Greathouse. I authorize such physician to submit claims on my behalf to my insurance carrier (including Medicare & Medicaid) for payment.

I understand I will receive regular statements of my account, reflecting the balance due and that the balance of my account remains my sole responsibility, regardless of payment or lack of payment by my insurance carrier.

This authorization and assignment is to remain in force until revoked in writing by the undersigned.

In the event suit is brought for collection, I agree to pay for attorneys fees in suit cost for collection.

*** Signature /Guardian** _____**Witness** _____**Date** _____

Board Certified in Rehabilitation by the American Chiropractic Association