Patient_____   Age_____   Birth Date_____

Address_____   Height_____   Weight_____

City_____ Zip_____   SS#_____

Phone (Home)_____   Driver's License #_____

Phone (Cell)   _____

Employer_____   Occupation_____

Employer's Address_____   Phone_____

Single ( )   Married ( )   Name of Spouse_____

Spouse's Employer_____   Occupation_____

Employer's Address_____   Phone_____

Were you in an automobile accident? **Yes** ( ) **No** ( )   Are you claiming this as a work injury? **Yes** ( ) **No** ( )

How were you referred to this office? _____

<div align="center">

OFFICE POLICY

</div>

CONFIDENTIALITY: All information disclosed during treatment is confidential and may not be revealed to anyone without written permission except where disclosure is required by law. Disclosure may be required in the following circumstances: where there is a reasonable suspicion of child abuse or elder physical abuse, where there is a reasonable suspicion that the patient presents a danger of violence to others or where the patient is likely to harm himself or herself unless protective measures are taken. Disclosure may also be required pursuant to legal proceedings. Threats communicated to family members that are then communicated to me may give rise to the duty to warn.

PAYMENT FOR SERVICE: You are expected to pay for services at the time they are rendered unless other arrangements have been made. In instances where extraordinary professional time is required, you may incur additional fees. Please notify the office if any problem arises during the course of your treatment regarding your ability to pay.

INSURANCE REIMBURSEMENT: Patients who carry insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. We will give you a receipt that you can submit to your insurance company for reimbursement. If your insurance company has forms for the doctor to complete, be certain to bring them in at your earliest convenience. Managed care insurance coverage does vary.

LIENS: You are personally responsible for all charges incurred in this office. If you, your attorney and Dr. Bock have entered into a lien, payment will be made promptly to Dr. Bock when sufficient monies are available from your attorney=s trust fund. This office will **not** reduce the amount of a lien, nor wait for health insurance companies to respond to billing.

EMERGENCY PROCEDURE: If you need to contact Dr. Bock outside office hours, please call the office and leave a message on our voice mail, he will return your call. If an emergency arises, Dr. Bock can be paged immediately.

CANCELLATION: Since the scheduling of an appointment involves the reservation of times specifically for you, a minimum twenty-four (24) hours notice is required for rescheduling or cancellation of an appointment. **We may charge you $50 for missed appointments without such notification; this charge cannot be billed to your insurance company.**

I have received a copy of Dr. Bock's Privacy Practices and Office Policy, and have read, understand and agree to abide by those policies.

_____   _____   _____
Date   Patient Signature   Patient's Representative

_____   _____
Date   Witness

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