Dr. Jane Leavell, DC
4045 Wadsworth Blvd, Suite 30
Wheat Ridge, CO 80033
(303) 452-7300 frontdesk@RhinoSC.com

Patient Registration Form - Adult

Patient Name: ____ ____________________
Last First Middle Nickname

____
Address City State Zip Code

Home Phone: ____________________________ Cell Phone: ______________________ Text? Y or N

Work Phone: ____________________________ Can you receive phone calls at work? Y or N

E-mail Address: ____________________________ How did you hear about us? ________________________

Date of Birth: _____ / _____ / _____ Age: ________ Sex: __________ Marital Status: ______________________

Occupation: ____________________________ Employer: ____________________________________

Emergency Contact: ____________________________________ Relationship: ______________________

_________________________ _____________________________ ______________________
Home Phone Cell Phone Work Phone

PAYMENT IS EXPECTED AT THE TIME OF VISIT

I understand that Rhino Scoliosis Center is not contracted with my insurance company, and that I am personally responsible for payment of all services provided to me. I also understand that this office will provide forms for submission to my insurance company as a courtesy to me. I certify that the above information is true and correct to the best of my knowledge. I will notify Rhino Scoliosis Center of any changes in status or the above information.

____
Initials

ACCEPTANCE AS A PATIENT

I understand and agree that the doctors of Rhino Scoliosis Center have the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of physical and radiological exams are not considered treatment, but are the process of information gathering so that the doctor can determine whether to accept me as a patient.

____
Initials

HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have had the opportunity to read Rhino Scoliosis Center's HIPAA Notice of Privacy Practices. I also understand a copy will be furnished to me upon request.

____
Initials

Patient Signature: ____ Date: ____________________