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

Patient Registration Form - Child

Patient Name: _____ _____
Last First Middle Nickname

Date of Birth: _____ / _____ / _____ Age: _____ Sex: _____ Grade: _____ School: _____

_____
Address City State Zip Code

Pt. Home Phone: _____ Pt. Cell Phone: _____ Text? Y or N

Patient E-mail Address: _____

Account Responsible: _____ Relationship: _____

_____
Address City State Zip Code

_____ _____ _____
Home Phone Cell Phone Work Phone

E-mail: _____ How did you hear about us? _____

Other Parent / Adult: _____ Relationship: _____

_____
Address City State Zip Code

_____ _____ _____
Home Phone Cell Phone Work Phone

E-mail: _____

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

Parent / Guardian Signature_____ Date: _____