BATEMAN – GATROST CHIROPRACTIC, P.C.

19501-B East 40 Highway; Independence, MO 64055 Phone: 816 / 795-5000 Fax: 816 / 795-5001

L. Wayne Bateman, D.C. Carlos A. Bateman, D.C. Albert L. Gatrost, D.C. Syrece K. Sherman, D.C.

Date:_____ **Account #**_____ **Doctor: LWB ALG CAB SKS**

***First Name**_____ **Nick Name**_____

***Last Name** _____ **Middle Name** _____ **Suffix** _____

Address _____

City_____ **State**_____ ***Zip Code** _____

Primary Phone _____ **Mobile Phone** _____

Secondary Phone _____ **Email** _____

By providing my email address, I authorize my doctor to contact me via the email address provided.

Contact Method *(check one)*

❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

***Date of Birth** / / **Age** _____ **SSN** _____ - _____ - _____

***Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified **Marital Status** *(check one)* ❑ Single ❑ Married ❑ Other

Spouse/Parent/Legal Guardian Name_____ **Phone**_____

Employment Status:*(check one)* ❑Employed ❑FT Student ❑PT Student ❑Other ❑Retired ❑Self Employed

*Occupation:_____

Employer Name:_____ Employer Phone:_____

Employer Address:_____

City:_____ State:_____ Zip:_____

Race *(check one)*

❑ White ❑ Black/African American ❑ American Indian/Alaskan Native ❑ Asian
❑ Native Hawaiian or other Pacific Island ❑Other_____ ❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English	❑ Spanish	❑ American Sign Language	❑ Chinese	❑ French	❑ German
❑ Tagalog	❑ Vietnamese	❑ Italian	❑ Korean	❑ Russian	❑ Polish
❑ Arabic	❑ Portuguese	❑ Japanese	❑ French Creole	❑ Greek	❑ Hindi
❑ Persian	❑ Urdu	❑ Gujarati	❑ Armenian	❑ I choose not to specify	

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

No interest ❑0 ❑1 ❑2 ❑3 ❑ 4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10 *Very Interested*

***Current Medications Prescribed by a doctor:** If there are no current medications, check here: ❑

Does your primary medical doctor have you on an Aspirin regimen? ❑ Yes ❑ No

Medication: ______________________________ Dosage: ______________ ❑Generic ❑Brand Name ❑Unknown

Start Date: ______________Current condition patient is taking medication for? ______________________________

Medication: ______________________________ Dosage: ______________ ❑Generic ❑Brand Name ❑Unknown

Start Date: ______________Current condition patient is taking medication for? ______________________________

Medication: ______________________________ Dosage: ______________ ❑Generic ❑Brand Name ❑Unknown

Start Date: ______________Current condition patient is taking medication for? ______________________________

Medication: ______________________________ Dosage: ______________ ❑Generic ❑Brand Name ❑Unknown

Start Date: ______________Current condition patient is taking medication for? ______________________________

Medication: ______________________________ Dosage: ______________ ❑Generic ❑Brand Name ❑Unknown

Start Date: ______________Current condition patient is taking medication for? ______________________________

***List any known allergies you have had to any medications. - If no allergies are known, check here:** ❑

1) ______________________________ 3) ______________________________
2) ______________________________ 4) ______________________________

Briefly list your main health problems: ______________________________

____

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No If yes, describe: ________

____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: ______________________________

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? ❑ Yes ❑ No

Primary Care Physician

*Provider Name______________________________Provider Phone/Fax:______________________

Provider Address:______________________________

City:______________________________State:____________________Zip:________________

Signature: ______________________________ **Date:** ______/______/______ **Chart #** ____________

To be performed by clinic staff: **Ht: ______in** **Wt: _____lbs**

BP: _____ / ______ **Heart Rate: ______bpm** **O2 ______** **Temp ______** **Resp/min______**

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Date: _____ Doctor: LWB ALG CAB SKS

Patient Name: _____ Account # _____

Reason for Visit

Purpose of this visit: ☐ Motor Vehicle Collision ☐ Slip/Fall ☐ Other: _____ In what State did this occur? _____
Date/Time of incident: _____ Were you: ☐ Driver ☐ Passenger ☐ Front Seat ☐ Back Seat
Wearing a seatbelt? ☐ Yes ☐ No Were you knocked unconscious? ☐ Yes ☐ No If yes, how long: _____
Where was the impact? ☐ Behind ☐ Front ☐ Driver's Side ☐ Passenger's Side Did airbag deploy? ☐ Yes ☐ No
Did you go to the Hospital? ☐ Yes ☐ No If yes, which hospital: _____
Transported to hospital via: ☐Ambulance ☐Drove Self ☐Driven by someone else. Were you admitted? ☐ Yes ☐ No
Have you gone to Urgent care or your PCP? ☐ Yes ☐ No If yes, Date and time: _____
Has a follow up been recommended by the treating doctor? ☐ Yes ☐ No If yes, Date and time: _____
In your own words, please describe the incident: _____
_____
_____

Did you have any physical complaints prior to the incident? ☐ Yes ☐ No If yes, please describe: _____
_____
Please describe your complaints and symptoms since the incident: _____
_____
Please list any activities of daily living or demands of employment that you could perform prior to the incident that you are unable to perform since the incident: _____
_____

Problem Areas:

*Describe your problem(s): _____
_____
*On a Scale of 0-10, rate the intensity: Lowest – 0 1 2 3 4 5 6 7 8 9 10 – Highest
*How did your problem begin: _____
_____
*Onset date of problem: _____
How often do you experience symptoms: _____
What is the nature of your symptoms (mark all that apply): ☐ Dull ☐ Sharp ☐ Throbbing ☐ Burning ☐ Deep ☐ Aching
☐ Tingling ☐ Stabbing ☐ Cramping ☐ Numbness ☐ Radiating
Does it affect other areas of your body: ☐ Yes ☐ No
To what areas does the pain radiate, shoot, travel: _____
What makes the problem worse? (time of day, movements, activities): _____
_____
What have you done to relieve the Symptoms? ☐ Prescription Medications ☐ Over the counter drugs
☐ Homeopathic remedies ☐ Physical Therapy ☐ Surgery ☐ Acupuncture
☐ Chiropractic ☐ Massage ☐ Ice ☐ Heat
☐ Other: _____
*What should we know about your current condition: _____
_____

Patient Name:_____ Account #_____ Date: ____/____/____

ACTIVITIES OF DAILY LIVING SUMMARY

Complete the following questionnaire as it relates to any activities (work or other) you would **normally be doing / enjoying**, but are **currently unable to perform normally** as a result of your injury (s), include all activities which you:

- Can no longer do or perform or enjoy
- Cannot do or perform/enjoy as you did **before** your injury

Job description _____

Specific work / school / home related challenges_____

_____

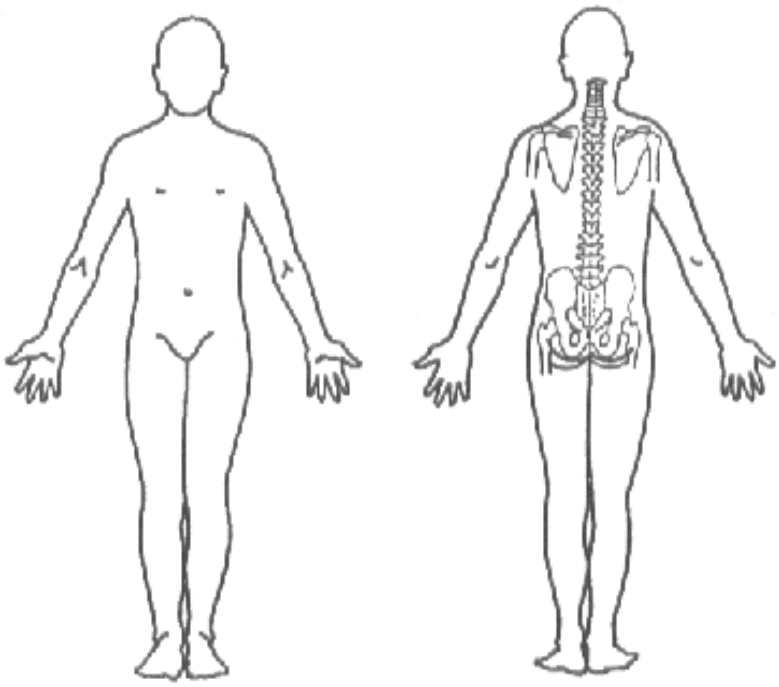
Please **CIRCLE** all activities that apply and rate the difficulty of the activity on a scale of 1-10(0 being the easiest, 10 most difficult):

Activity	Level of Difficulty	Reason for difficulty
Bending	0 1 2 3 4 5 6 7 8 9 10	□ Increased Pain □ Restricted movement □ Weakness
Carrying	0 1 2 3 4 5 6 7 8 9 10	□ Increased Pain □ Restricted movement □ Weakness
Driving	0 1 2 3 4 5 6 7 8 9 10	□ Increased Pain □ Restricted movement □ Weakness
Housework	0 1 2 3 4 5 6 7 8 9 10	□ Increased Pain □ Restricted movement □ Weakness
Lifting	0 1 2 3 4 5 6 7 8 9 10	□ Increased Pain □ Restricted movement □ Weakness
Lying	0 1 2 3 4 5 6 7 8 9 10	□ Increased Pain □ Restricted movement □ Weakness
Personal Care	0 1 2 3 4 5 6 7 8 9 10	□ Increased Pain □ Restricted movement □ Weakness
Pulling	0 1 2 3 4 5 6 7 8 9 10	□ Increased Pain □ Restricted movement □ Weakness
Pushing	0 1 2 3 4 5 6 7 8 9 10	□ Increased Pain □ Restricted movement □ Weakness
Reaching	0 1 2 3 4 5 6 7 8 9 10	□ Increased Pain □ Restricted movement □ Weakness
Reading	0 1 2 3 4 5 6 7 8 9 10	□ Increased Pain □ Restricted movement □ Weakness
Recreation	0 1 2 3 4 5 6 7 8 9 10	□ Increased Pain □ Restricted movement □ Weakness
Running	0 1 2 3 4 5 6 7 8 9 10	□ Increased Pain □ Restricted movement □ Weakness
Shopping	0 1 2 3 4 5 6 7 8 9 10	□ Increased Pain □ Restricted movement □ Weakness
Sit to Stand	0 1 2 3 4 5 6 7 8 9 10	□ Increased Pain □ Restricted movement □ Weakness
Sitting	0 1 2 3 4 5 6 7 8 9 10	□ Increased Pain □ Restricted movement □ Weakness
Sleeping	0 1 2 3 4 5 6 7 8 9 10	□ Increased Pain □ Restricted movement □ Weakness
Standing	0 1 2 3 4 5 6 7 8 9 10	□ Increased Pain □ Restricted movement □ Weakness
Walking	0 1 2 3 4 5 6 7 8 9 10	□ Increased Pain □ Restricted movement □ Weakness
Writing	0 1 2 3 4 5 6 7 8 9 10	□ Increased Pain □ Restricted movement □ Weakness
Other: _____	0 1 2 3 4 5 6 7 8 9 10	□ Increased Pain □ Restricted movement □ Weakness

Pain Chart

0 = No pain / 5 = Medium pain / 10 = Severe pain

Circle areas of discomfort on figures



Head-Neck-Shoulder-Arm Pain

On a scale of 0-10, I rate my discomfort as follows:
Lowest – **0 1 2 3 4 5 6 7 8 9 10** – Highest

Mid-Back Pain

On a scale of 0-10, I rate my discomfort as follows:
Lowest – **0 1 2 3 4 5 6 7 8 9 10** – Highest

Low-Back-Hip-Leg Pain

On a scale of 0-10, I rate my discomfort as follows:
Lowest – **0 1 2 3 4 5 6 7 8 9 10** – Highest

Medical History

Illnesses:

Illness: _____ Start date: _____ End date: _____
Illness: _____ Start date: _____ End date: _____
Illness: _____ Start date: _____ End date: _____

Surgeries:

Surgery: _____ Date: _____
Surgery: _____ Date: _____

Hospitalizations:

Reason: _____ Date: _____ Duration: _____
Reason: _____ Date: _____ Duration: _____
Reason: _____ Date: _____ Duration: _____

Injuries:

Injury: _____ Date: _____
Injury: _____ Date: _____
Injury: _____ Date: _____

Have you seen a Chiropractor before? □ Yes □ No If yes, list name of doctor and date(s): _____
_____

Did the treatment received help your condition? □ Yes □ No
What condition were you treated for? _____
How long were you treated? _____

Family History

Please review the diseases and conditions listed below and indicate the type of disease that are current health problems of the family member listed. Leave those spaces blank that do not apply. Circle your answers if your relatives live around this locality, as some hereditary conditions are affected by similar climate.

CONDITIONS:	FATHER	MOTHER	BROTHER(S)	SISTER(S)	SON(S)	DAUGHTER(S)
Year Born						
Age / Cause of Death						
Caner (Type)						
Clotting Issue (Type)						
Dementia / Alzheimer's						
Diabetes / Pre-Diabetic						
Gastrointestinal (Type)						
Heart Disease (Type)						
High Cholesterol						
Disc Problems						
Hypertension						
Kidney Disease (Type)						
Lung Disease (Type)						
Osteoporosis						
Psychological (Type)						
Septicemia						
Stroke / Brain Attack						
SIDS						
Arthritis / Gout (Type)						
Bursitis						
Headaches						
Liver Disorder						
Nerve Pain						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Thyroid						
Other:						

Social History

Consumption:

How many ounces of liquid do you consume on a daily basis? ____Water ____Coffee ____Soda ____Alcohol ____Other
How much do you depend on pain relievers? _____

Stress/ Sleep Information:

*How much physical stress are you under: Not much – 0 1 2 3 4 5 6 7 8 9 10 – A lot
*How much emotional stress are you under: Not much – 0 1 2 3 4 5 6 7 8 9 10 – A lot
How many hours do you sleep per night: _____
What is your preferred sleeping position: _____

Healthy Eating and Exercise Information:

How much regular exercise do you perform: _____
*Rate your healthy eating habits: Not healthy – 0 1 2 3 4 5 6 7 8 9 10 – Healthy
Typical eating habits (mark all that apply): ___ Skip breakfast ___ 2 meals per day ___ 3 meals per day
___ Snacking between meals

Acknowledgements

Chiropractic care:

☐ I instruct the chiropractor to deliver the care that, in his or her professional judgment,can best help me in the restoration of my health. I also understand that thechiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease orentity.

Privacy Verification:

☐ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Permission to contact:

☐ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Payment Verification:

☐ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

X-ray Verification:(females only)

☐ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant or I understand the risks. Date of last menstrual period:

General Verification:

☐ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Signature:_____ Date: _____

Bateman-Gatrost Chiropractic-Motor Vehicle Collision/Personal Injury Filing Policy

Patient's Name:_____ **Account #:**_____ **Today's Date:**_____/_____/_____

Due to the fact that the doctors at Bateman-Gatrost Chiropratic are participating providers with most health insurance plans we are required by contract to bill the most responsible party. Therefore a Doctor's Lien will be filed with the attorney, med pay and/or third party liability insurance company as applicable. Our office will send all billing and medical records to these parties on your behalf for reimbursement. Bateman-Gatrost Chiropractic, P.C. will be reimbursed **100%** for services rendered.

It is important to understand that all monies received by the patient for services rendered at Bateman-Gatrost Chiropractic, P.C. are to be brought to the office to be applied to the account and that although your attorney, med pay or third party liability may pay less than the actual bill for services, you agree to pay the balance within 30 days. Even though you are ultimately responsible for yourself and your dependents, Bateman-Gatrost Chiropractic, P.C. will wait for settlement of your claim up to **ninety (90) days** after your care is completed. If your claim has not been settled by the end of the 90 days, you hereby agree to pay the account balance in full. **If you suspend or discontinue care at any time, you hereby agree to pay the account balance immediately.**

Initials: _____

I do hereby authorize the above Chiropractic facility to furnish my attorney/insurance company(s), with a full report of this case history, examination, diagnosis, treatment and prognosis of myself and/or my dependent in regard to the accident/illness, which occurred or began on:

Date of Accident: _____/_____/_____ **State:** _____ **Initials:** _____

____**OPTION 1:** I would like to pay **Cash** at time of service.

____**OPTION 2**: I would like to file **Med Pay** insurance coverage provided by **my** auto insurance.
Insurance Company:_____
Insurance Address: _____
Insurance Adjuster's Name:_____
Adjuster's Phone Number:_____
Claim Number:_____

____**OPTION 3:** I would like to file **Third Party Liability** insurance coverage provided by the **other party's** auto insurance.
Insurance Company:_____
Insurance Address: _____
Insurance Adjuster's Name:_____
Adjuster's Phone Number:_____
Claim Number:_____

____**OPTION 4**: I would like to file with my **Attorney.**
Legal Firm: _____
Attorney's Name:_____
Address:_____
Telephone Number:_____

I have read, understand and agree to the terms of the Bateman-Gatrost Chiropractic Motor Vehicle Collision/Personal Injury Filing Policy. Should I default on the terms of this agreement, I understand my account will be turned over to collections without notice and I will be responsible for all fees incurred to resolve this issue.

_____ _____ ____/____/____
Print Patient's Name Witness Date

_____ _____ ____/____/____
Patient/Legal Guardian Signature Relationship Date

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COMMERCIAL ASSIGNMENT OF BENEFITS & RELEASE:

I, THE UNDERSIGNED, HAVE INSURANCE COVERAGE AND, IN CONSIDERATION OF SERVICES RENDERED, ASSIGN DIRECTLY TO BATEMAN – GATROST CHIROPRACTIC, P.C. ALL PAYMENTS FROM MEDICAL HEALTH BENEFITS, AND / OR ANY PAYMENTS FROM MY ATTORNEY, THIRD PARTY PAYOR, MEDICAL / PIP COVERAGE, IF ANY, OTHERWISE PAYABLE TO ME. I AUTHORIZE THE RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL MY INSURANCE SUBMISSIONS WHETHER MANUAL OR ELECTRONIC.

PATIENT INITIALS_____

MEDICARE AUTHORIZATION:

I REQUEST PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE ON MY BEHALF TO BATEMAN – GATROST CHIROPRACTIC, P.C. FOR ANY SERVICES FURNISHED TO ME BY SAID PROVIDER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO BATEMAN – GATROST CHIROPRACTIC, P.C. AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

I UNDERSTAND THAT MEDICARE & MEDICARE ADVANTAGE INSURERS REQUIRE AN EXAM AND NECESSARY X-RAYS; HOWEVER, MEDICARE AND MEDICARE ADVANTAGE INSURERS **DO NOT COVER** ANY CHARGES FOR **EXAM, X-RAY, OR THERAPY**.
MEDICARE & MEDICARE ADVANTAGE INSURERS COVER **SPINAL ADJUSTMENTS ONLY.**

PATIENT INITIALS_____

AUTHORIZATION TO DISCLOSE INFORMATION:

I, THE UNDERSIGNED, HERE BY AUTHORIZE BATEMAN-GATROST CHIROPRACTIC TO RELEASE ANY AND ALL INFORMATION REGARDING MY CONDITION, TREATMENT, AND FINANCIAL STATUS AS IT RELATES TO MY CASE TO THE FOLLOWING:

1.) _____ PHONE #: _____
2.) _____ PHONE #: _____
3.) _____ PHONE #: _____

PATIENT FINANCIAL AGREEMENT:

I, THE UNDERSIGNED, AGREE TO PAY FOR THE BALANCE OF MY ACCOUNT. ALTHOUGH AN INSURANCE CLAIM (IF APPLICABLE) WILL BE FILED WITH MY INSURANCE COMPANY ON MY BEHALF, NEGOTIATING PAYMENT THROUGH MY INSURANCE COMPANY ULTIMATELY IS MY OBLIGATION. IF I HAVE NO INSURANCE, I AGREE THAT PAYMENT WILL BE MADE AT THE TIME SERVICES ARE RENDERED UNLESS FINANCIAL ARRANGEMENTS HAVE BEEN MADE **PRIOR** TO THE SERVICES. A STATEMENT WILL BE MAILED MONTHLY SHOWING ANY BALANCE DUE FROM ME AND IS CONSIDERED PAST DUE WITHIN 30 DAYS FROM RECEIPT. IF I DO NOT RECEIVE A STATEMENT WITHIN 45 DAYS OF MY VISIT, IT IS MY RESPONSIBILITY TO CONTACT BATEMAN – GATROST CHIROPRACTIC, P.C. TO VERIFY MY CURRENT ADDRESS AND ANY BALANCE DUE. IF I AM UNABLE TO MAKE PAYMENT IN FULL, I SHOULD CALL THE BILLING DEPARTMENT IMMEDIATELY TO MAKE PAYMENT ARRANGEMENTS.

I UNDERSTAND THAT ITEMS BILLED TO INSURANCE BECOME PAST DUE IF NO REPLY IS RECEIVED WITHIN 45 DAYS. I UNDERSTAND THAT IF NO PAYMENT HAS BEEN RECEIVED OR FINANCIAL ARRANGEMENTS MADE ON MY BALANCE AFTER 45 DAYS, MY ACCOUNT MAY BE REFERRED FOR COLLECTION. IF REFERRED FOR COLLECTION, I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR THE BALANCE AS WELL AS ANY FEES INVOLVED IN THE COLLECTION PROCESS.

TREATMENT TIME IS VALUABLE, **IF YOU CANNOT KEEP YOUR APPOINTMENT PLEASE CALL**; OTHERS MAY NEED CARE. IT IS THE GOAL OF BATEMAN-GATROST CHIROPRACTIC, P.C. TO ALWAYS PROVIDE THE BEST STANDARD OF CARE POSSIBLE. STRICT ADHERENCE TO THE PRESCRIBED TREATMENT PLAN WILL MAXIMIZE THE OUTCOME OF CARE**.**

I UNDERSTAND IT IS MY RESPONSIBLITY TO PROVIDE CURRENT IDENTIFICATION VERIFICATION AND INSURANCE CARD AT CHECK IN. TIME OF SERVICE CHARGE IS PROVIDED AND PAYMENT IN FULL IS REQUIRED THE SAME DAY OF SERVICE.

_____ _____
Patient Name – please print Date

_____ _____
Patient Signature/Parent or Legal Guardian if minor Relationship to Patient

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Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:_____ **Date of Birth:**_____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of Bateman-Gatrost Chiropractic P.C..

I understand that the Notice describes the uses and disclosures of my protected health information by Bateman-Gatrost Chiropractic P.C. and informs me of my rights with respect to my protected health information.

Patient's Signature or that of Legal Representative | *Printed Name of Patient or that of Legal Representative*

Today's Date | *If Legal Representative, Indicate Relationship*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):_____

Employee Name | *Today's Date*

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Please provide us with your email address to start managing your health care from the web.

Name: _____ DOB: ____/____/____

Email Address: | |

Verification Question *(choose only one question by marking the question, then give the answer to that question)*

- ❑ What is the name of your favorite pet?
- ❑ In what city were you born?
- ❑ What is your favorite movie?
- ❑ What is your mother's maiden name?
- ❑ On what street did you grow up?
- ❑ What was the make of your first car?

Verification Answer to the Chosen question: _____

Answers must be at least 6 characters.

We are collecting your email address for our records and will use it to issue you an invitation to access your treatment summaries via our secure Patient Portal. We also hope to send appointment reminders via email and to provide you more online communication with our office in the future. We will not disclose your email address to others without your prior written consent and it will not be used for any solicitations.