

CLIENT CHANGE OF ADDRESS/PHONE FORM

CLIENT NAME: _____

Check one: Mr. Ms. Mrs. Mr. & Mrs. Other

Address _____

City _____ State _____ Zip Code _____ County _____

Phone Number (____) _____ - _____ Name _____ home work cell

Phone Number (____) _____ - _____ Name _____ home work cell

E MAIL ADDRESS: _____

The above information is personal and confidential. Medical information will be released ONLY to the LEGAL owner(s) LISTED ON ACCOUNT with written permission. We will confirm OWNER'S driver's license number and/or birthdate prior to the release of patient information to ensure privacy. PAYMENT IS DUE AT THE TIME OF SERVICE.

OWNER SIGNATURE _____ DATE _____