

ALTERNATIVE MEDICINE & THERAPY QUESTIONNAIRE

Please fill out all required information that you would like added to MedLic's doctor directory.

NOTE: License/Permit/Certification # will not be displayed on the directory. It is for MedLic's use ONLY.

Name: Please specify any title after your name.

Field of Medicine: Example (Chiropractor, Physical Therapist, Massage Therapist, Acupuncturist, Nutritionist, etc.)

Name of Clinic or Facility: _____

Name: _____

License # _____

Permit # _____

Certification # _____

Field of Medicine: _____

Physical Address: _____

Mailing Address: _____

(Please specify if the same)

County: _____

Office Number: _____

Fax Number: _____

Office E-mail: _____

(NOTE: needed for e-mail confirmations and courtesy updates ONLY.)

Name of Office Manager: _____

Office Manager's direct line: _____

Office Manager's E-mail: _____

Hours of Operation: _____

Non days of operation (Holidays observed): _____

If you have more than one location, please add as many locations as you would like listed in the directory.

Location #2 Address:

Physical Address: _____

Mailing Address: _____

(Please specify if the same)

County: _____

Office Number: _____

Fax Number: _____

Office E-mail: _____

(NOTE: needed for e-mail confirmations and courtesy updates ONLY.)

Name of Office Manager: _____

Office Manager's direct line: _____

Office Manager's E-mail: _____

Hours of Operation: _____

Non days of operation (Holidays observed): _____

Location #3 Address:

Physical Address: _____

Mailing Address: _____

(Please specify if the same)

County: _____

Office Number: _____

Fax Number: _____

Office E-mail: _____

(NOTE: needed for e-mail confirmations and courtesy updates ONLY.)

Name of Office Manager: _____

Office Manager's direct line: _____

Office Manager's E-mail: _____

Hours of Operation: _____

Non days of operation (Holidays observed): _____

Appointments needed? Yes _____ No _____

Walk-ins accepted? Yes _____ No _____

Payment type accepted: Visa ___ MC ___ AE ___ Disc ___ Money Order _____

Cash ___ Personal Checks ___ Cashier's Check _____ Debit Card _____

(NOTE: All discounted rates per MedLic's Agreement will apply, unless the doctor's office chooses to accept the Athlete's personal insurance information. MedLic assumes no responsibility for any outstanding debt the Athlete may incur. Accepting insurance from an Athlete voids this contract and agreement for current appointment ONLY.)

List of services and prices contracted for MedLic, LLC.

Exam: _____

MedLic's Contracted Price: \$ _____

Original Price: \$ _____

Exam: _____

MedLic's Contracted Price: \$ _____

Original Price: \$ _____

Exam: _____

MedLic's Contracted Price: \$ _____

Original Price: \$ _____

Exam: _____

MedLic's Contracted Price: \$ _____

Original Price: \$ _____

Exam: _____

MedLic's Contracted Price: \$ _____

Original Price: \$ _____

If your office provides a multitude of services, please forward a list and send it to info@mymedlic.com along with MedLics discounted prices.

By signing this document, you are agreeing and allowing MedLic, LLC to list the contracted prices above in their directory.

Print Name: _____

Doctor Signature: _____

Date: _____



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