

Life Chiropractic College West Health Center

Field Chiropractor Imaging account application

Start Date: _____ LCCW account # _____

Chiropractor's Name: _____

Practice Name: _____

Practice Address: _____

City, State, Zip code: _____

Practice phone: _____ Other phone: _____

License #: _____ Renewal Date: _____

Credit Card Information

Type of card: VISA MasterCard Discover American Express

Card number: _____ Exp: _____

Code: _____

To set up new account fill out and fax or email this form to:

Jon Nichols, DC

Fax 510 780-4511

Email: jnichols@lifewest.edu

Once account is established, please fill out x-ray request form and fax to:

510 780-4511

Questions contact please Jon Nichols, DC 510 780-4500 x2244