



Patient Name (Please Print): _____

Today's Date: _____

PATIENT APPLICATION FORM

WELCOME TO OUR CLINIC. We specialize in assisting our patients to achieve their highest level of health through our many services. We focus on the patient and his or her specific needs. We provide a custom care plan that is unique and specialized for each patient. Each patient is given a thorough exam and the doctor will provide multiple options of care so that the patient can choose the care plan that works best for their specific case.

We provide several types of care, including:

- Complete Spinal and Postural Corrective Programs
- Advanced Acute Chiropractic Rehabilitation Programs
- Spinal Rejuvenation Decompression Programs
- Sports, Auto Accident and Work Related Injury Rehabilitation
- Specific Extremity Rehabilitation
- Cold or Low Level Laser Therapy
- Supportive & Wellness Programs
- Nutritional Support Programs
- Massage Therapy

Our approach is very unique and advanced from other rehabilitative programs. This allows our patients to achieve far superior results compared to most other systems.

Please fill out the following information accurately and completely so that the doctor can thoroughly evaluate your case. The doctor will use this information, along with your history, examination and x-rays (if required) to determine if you qualify for one of our rehabilitative programs. If you need assistance, please feel free to ask questions. We look forward to serving you.

CONFIDENTIAL PATIENT INFORMATION

Patient Name: _____ Age: _____ Gender: M F
Home Address: _____ Home Phone: () _____
City, State, Zip: _____ Work Phone: () _____
Email Address: _____ Cell Phone: () _____

Birth Date: ____/____/____ Marital Status: S M D W
Employer Name: _____ Occupation: _____

Spouse's Name: _____ Work Phone: () _____ Cell Phone: () _____
Spouse's Employer: _____ Occupation: _____

Emergency Contact: _____ Relation: _____
Home Phone: () _____ Cell/Work Phone: () _____

Names of Children(Ages): _____
How were you referred to this office? _____

Do you have Health Insurance: [] Yes [] No Type of Insurance: [] Commercial/Private [] Medicare [] Medicaid
Primary Insured / Party Responsible for Billing: (complete only if different from above)
(Please allow our staff to photocopy your driver's license and all insurance cards)

Patient's Relationship to Primary Insured / Party Responsible for Billing: [] Self [] Spouse [] Child/dependent [] Other: _____
Insured's Name: _____

Insured's Birth Date: ____/____/____ Age: _____ Gender: M F Marital Status: S M D W
Insured's Address: _____ Insured's Home Phone: () _____
City, State, Zip: _____ Insured's Work Phone: () _____
Email Address: _____ Insured's Cell Phone: () _____

Employer Name: _____ Occupation: _____
Spouse's Name: _____ Work Phone: () _____ Cell Phone: () _____
Spouse's Employer: _____ Occupation: _____

Primary Insurance Company: _____ Policy ID: _____ Group #: _____
Secondary Insurance Company: _____ Policy ID: _____ Group #: _____

AUTHORIZATIONS:

- A. I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I (we) understand that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or not covered. I understand I am responsible for all co-payments, deductibles and non-covered services. I also understand and agree to pay all co-pays and fees for non-covered services prior to seeing the doctor. I understand that if I terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.
B. I (we) authorize the doctor and his staff to release any information deemed appropriate concerning my physical condition to an insurance company, claims adjuster, case nurse, claims reviewer, employer, health care provider or attorney in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered and hereby release him/her of any consequences thereof.
C. I (we) hereby authorize and direct payment from third-parties for any medical/chiropractic benefits allowable to the doctor as payment toward the total charges for professional services rendered to be paid directly to this office/doctor. This payment will not exceed my indebtedness to the assignee.
D. I (we) authorize this office to maintain a photocopy of my driver's license and all available insurance cards. I agree that a photostatic copy of this agreement shall serve as the original.
E. We are required by law to provide you with the HIPAA NOTICE of PRIVACY PRACTICES that explains our privacy practices with regard to your medical information and how we may use and disclose your protected health information for treatment, payment, and for health care operations, as well as for other purposes that are permitted or required by law. You have certain rights regarding the privacy of your protected health information and we also describe them in this notice. By signing below I agree that I have been provided the opportunity to read and have a copy of the clinic HIPPA Notice of Privacy.

My Preferred Payment Option(s) (please indicate): [] Cash [] Check [] Visa [] Mastercard [] Discover

Patient Signature: _____ Date: _____

If patient is under 18 yoa;

Parent/Guarding Signature: _____ Date: _____

Parent/Guarding Name(please print): _____

CONFIDENTIAL PATIENT INFORMATION

Patient Name: _____

Date: _____

PURPOSE OF THIS VISIT

Reason for this visit – Main Complaint(s): _____

Place an "X" on the drawing below on the area(s) causing you pain and label each area by the type of pain.

A=Ache & Dull
B=Burning
S=Stabbing
N=Numbness
P=Pins & Needles

When did this symptoms or condition begin? _____

How did it begin: Gradual Sudden Intermittently or Comes & Goes Unknown

Please describe how it began: _____

Is this complaint related to a Trauma or Injury? Yes No If so, when did it occur: _____

Type of Trauma: Auto Accident Work Injury Fall Sports Injury Other:

Describe the trauma: _____

Have you experienced this condition before? Yes No If Yes, when and please explain: _____

Has this condition become worse recently? Yes No

If Yes, how has is worsened: Gradually Worse Abruptly Worse Erratic

If No, has it: Remained the Same Gotten Better

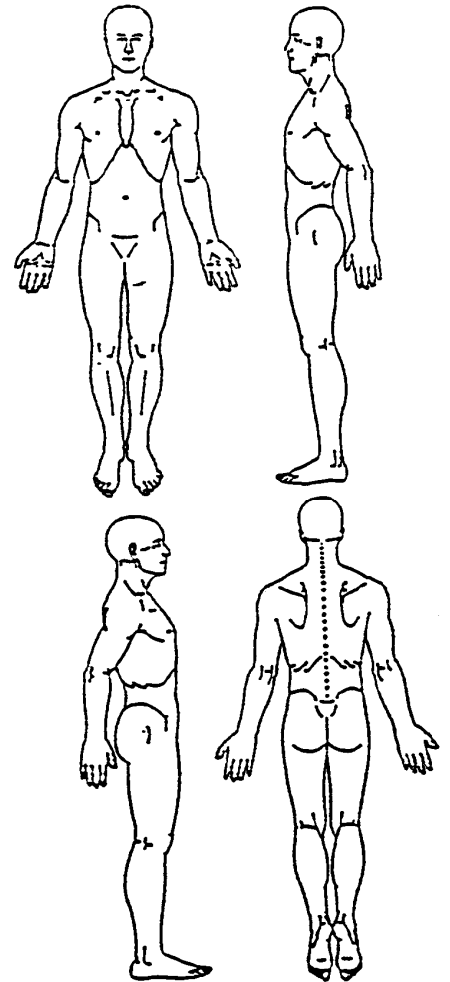
What activities aggravate your complaint(s)? _____

Is there anything, which has relieved your complaint(s)? Yes No If Yes, describe: _____

If No, please describe what you tried that did not help: _____

Type of Pain (check all that apply):

Sharp Dull Ache Burning Throbbing Spasm Numbness Tingling Shooting



Office Use Only:

Doctor's notes

CONFIDENTIAL PATIENT INFORMATION

Patient Name:

Date:

PURPOSE OF THIS VISIT CONT.

Please rate Your Current Level of Pain Right Now (circle number below) (If more than one area please identify each area):

0 1 2 3 4 5 6 7 8 9 10

0 = no pain ----- 10 = Severe / worst pain you have ever experienced

Please rate Your Typical or Average Pain level (circle number below) (If more than one area please identify each area):

0 1 2 3 4 5 6 7 8 9 10

0 = no pain ----- 10 = Severe / worst pain you have ever experienced

Please rate Your Pain level when it is At Its Best (circle number below) (If more than one area please identify each area):

0 1 2 3 4 5 6 7 8 9 10

0 = no pain ----- 10 = Severe / worst pain you have ever experienced

Please rate Your Pain level when it is At Its Worst (circle number below) (If more than one area please identify each area):

0 1 2 3 4 5 6 7 8 9 10

0 = no pain ----- 10 = Severe / worst pain you have ever experienced

Does the pain radiate or travel into your:

- Head or Face Arm Leg Around your Chest Does not Radiate or Travel

How often does your complaint(s) affect you? Daily 4-6X's/Week 2-3X's/Week 1X/Week other:

How often do you experience these symptoms throughout the day? 100% 75% 50% 25% 10% Only with Activity

Does complaint(s) interfere with: Work Sleep Hobbies Daily Routine Explain:

Are your symptoms Worse: in the Morning in the Afternoon in the Evening No change through-out day other:

Are your symptoms Better: in the Morning in the Afternoon in the Evening No change through-out day other:

Who have you seen for this? What did they do?

How did you respond?

Have you had any changes in bodily functions since the condition began? Yes No if Yes, please check all that apply:

- Balance Bowl Habits Breathing Vision Weakness Grip Strength
Coordination Urination Coughing Hearing Fatigue Weight Loss
Gait Menstrual Sneezing Sexual Function Temperature Weight Gain

Office Use Only:

Doctor's notes

Blank lines for office use and doctor's notes.

CONFIDENTIAL PATIENT INFORMATION

Patient Name:

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PURPOSE OF THIS VISIT CONT.

Are you currently under medical care for this complaint(s) or any other health condition? Yes No If Yes, please explain: _____

Are You Now or Could You be Pregnant? Yes No

Do you have a pacemaker or any other surgically implanted devices? Yes No if Yes, please explain: _____

Do you have any other Complaints or concerns with your health? _____

EXPERIENCE WITH CHIROPRACTIC

Have you ever received Chiropractic care before? Yes No If yes, with whom? _____

Date of last visit _____ For how long were you receiving care? _____

How frequent were your visits _____ Reason for visits: _____

How did you respond? _____ Reason for ending care: _____

Were you pleased with his/her service? Yes No Did your previous chiropractor perform before and after exam & x-rays? Yes No

Are you aware that posture is an important determinant of one's overall health and conveys valuable health information? Yes No

Are you aware of any of your poor posture habits? Yes No Explain: _____

Are you aware of any poor posture habits in your spouse or children? Yes No Explain: _____

Have you ever been told or felt like you carry your head forward, noticed a rounding of your shoulders, noticed a developing "hump" at the base of your neck, or noticed at the end of each day that you have a tight neck? Yes No

HEALTH LIFESTYLE – SOCIAL HISTORY

In general, would you say your health is: Excellent Very Good Good Fair Poor

Compared to one year ago, how would you rate your health in general now?

- Much better now than one year ago Somewhat worse than one year ago
 Somewhat better now than one year ago Much worse than one year ago
 About the same

Where do you consider your health? Highest Priority High Priority Average Priority Low Priority Haven't thought about it.

Do you consciously exercise, eat nutritious meals, minimize stress and do things to maintain good health or improve your health? Yes No

Do you exercise? Yes No How often? 1X 2X 3X 4X 5X per week other: _____

What activities? Walking Jogging Weight Training Cycling Yoga Pilates Swimming other: _____

What is your current Height and Weight? Height: _____ ft _____ inches Weight: _____ lbs

Do you smoke? Yes No How much? 1-5 cig/day 6-10 cig/day 1 pack/day > 1 pack/day: _____

Do you drink alcohol? Yes No How much / week on average? _____

Do you drink coffee/caffeinated drinks? Yes No How many cups / day? _____

Do you currently have a drug or substance abuse problem? Yes No If yes, discuss with doctor.

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Date: _____

HEALTH LIFESTYLE – SOCIAL HISTORY CONT.

Please describe you Work.

Type: Professional Physical Labor Driver Clerical Factory Homemaker Other: _____

Physical Demands: Heavy Moderate Mild Sedentary

Stress Level: High Medium Low

Do you currently take any prescription or non-prescription drugs or supplements (i.e. vitamins, minerals, herbs)? Please list below:

Name	Reason for taking	Name	Reason for taking

REVIEW OF SYSTEMS

1. Do you have skin, hair or nail problems? Yes No _____
 2. Do you have mouth and/or throat problems? Yes No _____
 3. Do you have nose and/or sinus problems? Yes No _____
 4. Do you have ear problems? Yes No _____
 5. Do you have eye problems? Yes No _____
 6. Do you have chest or lung (breathing) problems? Yes No _____
 7. Do you have heart and/or blood vessel problems? Yes No _____
 8. Do you have blood or lymph node problems? Yes No _____
 9. Do you have digestive problems? Yes No _____
 10. Do you have genital problems (e.g. prostate, testicular, vaginal, uterus)? Yes No _____
 11. Do you have Urinary (including kidney or bladder) problems? Yes No _____
 12. Females: Do you have menstrual problems? Yes No _____
- _____
- Have you ever taken birth control pills? Yes No Currently taking? Yes No How long : _____ yrs
- Is there any chance that you are currently pregnant? Yes No
- Do you have any breast problems? Yes No _____
13. Do you have any nervous system diseases and/or mental health problems? Yes No _____
 - _____
 14. Do you have any gland and/or hormone problems? Yes No _____
 15. Do you have any allergy or immunity problems? Yes No _____
 16. Do you have any muscle, tendon or ligament problems? Yes No _____
 17. Do you have any bone or joint diseases (examples: bone = osteoporosis, joint = arthritis)? Yes No _____
 - _____

CONFIDENTIAL PATIENT INFORMATION

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PAST MEDICAL HISTORY

- 1. List any diseases that you have had in the past, including childhood diseases:
2. Have you ever been diagnosed with or told by another medical doctor that you have a particular condition, such as diabetes, cancer, AIDS, cardiovascular disease, etc.:
3. Have you suffered any physical injuries, such as falls or blows, automobile accidents, whiplash, concussion or head trauma, lacerations, sprains, strains, dislocations, broken or cracked bones?
4. List any surgeries or operations you have had (don't forget appendix, tonsils, ear tubes, vasectomy, hysterectomy):

- 1. date: 5. date:
2. date: 6. date:
3. date: 7. date:
4. date: 8. date:

FAMILY MEDICAL HISTORY

Please note any family history of the below conditions and note the relationship of relative.

M = Mother, F = Father, S = Sibling, ♀GP = Maternal Grandparent, ♂GP = Paternal Grandparent

- ☐ Cancer: ☐ M ☐ F ☐ S ☐ ♀GP ☐ ♂GP
☐ Diabetes: ☐ M ☐ F ☐ S ☐ ♀GP ☐ ♂GP
☐ High Blood Pressure: ☐ M ☐ F ☐ S ☐ ♀GP ☐ ♂GP
☐ Heart Disease: ☐ M ☐ F ☐ S ☐ ♀GP ☐ ♂GP
☐ Arthritis: ☐ M ☐ F ☐ S ☐ ♀GP ☐ ♂GP
☐ Stroke: ☐ M ☐ F ☐ S ☐ ♀GP ☐ ♂GP
☐ Headaches: ☐ M ☐ F ☐ S ☐ ♀GP ☐ ♂GP
☐ Spine or Back Disorders: ☐ M ☐ F ☐ S ☐ ♀GP ☐ ♂GP
☐ Multiple Sclerosis: ☐ M ☐ F ☐ S ☐ ♀GP ☐ ♂GP
☐ Psychological Disorders: ☐ M ☐ F ☐ S ☐ ♀GP ☐ ♂GP

Are there any other diseases or conditions that are common among your family members, (ie, inherited diseases or conditions)? ☐ Yes ☐ No

Describe:

Office Use Only: Doctor's notes

CONFIDENTIAL PATIENT INFORMATION

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HEALTH CONDITIONS

Abnormal postural habits or distortions of our bodies are the result of trauma, stress, unbalanced muscles and the affect of gravity on our bodies. When any part of our body becomes misaligned and unbalanced from its normal position, this will cause stress to the nervous system and structures of our body. These misalignments are called Subluxations (sub-lux-a-shuns) and they cause poor biomechanics within the joints of our bodies. This alteration of biomechanics not only stresses the nervous system but weakens the physical structures of our body leaving us more prone to injury and degeneration. It has been extensively documented that subluxations, causing stress to your nerves, will weaken and distort the overall structure of your spine. This results in a weakened and distorted POSTURE. Postural distortions have many serious and adverse affects on your overall health. The most common and detrimental postural distortion is called Forward Head Posture (a "hunched forward" posture starting in the neck and progressively moving down your spine weakening the entire body).

Our bodies are one complete integrated system, any injury to our foot will affect our knee, hip and spine. A neck injury such as whiplash can affect our entire body. Please review the health conditions below and identify which condition or symptom you are currently experiencing (current is defined within the last 3 to 6 months) or you have experienced in the past (longer than 6 months ago).

Check the box next to "C" for current condition, "P" for past condition, or you may check both boxes.

CERVICAL SPINE (NECK) including the upper extremity:

Postural distortions from subluxations, (causing Forward Head Syndrome), in your neck will weaken the nerves into your arms, hands and head affecting these parts of your body. Do you experience...?

- | | | |
|---|---|---|
| <input type="checkbox"/> C <input type="checkbox"/> P Neck Pain | <input type="checkbox"/> C <input type="checkbox"/> P Eye Redness or Discharge | <input type="checkbox"/> C <input type="checkbox"/> P Loss of Smell |
| <input type="checkbox"/> C <input type="checkbox"/> P Neck Stiffness | <input type="checkbox"/> C <input type="checkbox"/> P Dry Eyes | <input type="checkbox"/> C <input type="checkbox"/> P Allergies/Hay Fever |
| <input type="checkbox"/> C <input type="checkbox"/> P Neck Lump or Mass | <input type="checkbox"/> C <input type="checkbox"/> P Dizziness | <input type="checkbox"/> C <input type="checkbox"/> P Nasal Discharge |
| <input type="checkbox"/> C <input type="checkbox"/> P Headaches: Stress | <input type="checkbox"/> C <input type="checkbox"/> P Loss of Balance | <input type="checkbox"/> C <input type="checkbox"/> P Recurrent Colds/Flu |
| <input type="checkbox"/> C <input type="checkbox"/> P Headaches: Migraine | <input type="checkbox"/> C <input type="checkbox"/> P Spinning Sensation or Vertigo | <input type="checkbox"/> C <input type="checkbox"/> P Low Energy/Fatigue |
| <input type="checkbox"/> C <input type="checkbox"/> P Pain into your Shoulders/Arms/Hands | <input type="checkbox"/> C <input type="checkbox"/> P Ear Pain | <input type="checkbox"/> C <input type="checkbox"/> P TMJ/Pain/Clicking |
| <input type="checkbox"/> C <input type="checkbox"/> P Numbness/Tingling in Arms/Hands | <input type="checkbox"/> C <input type="checkbox"/> P Ringing in Ears | <input type="checkbox"/> C <input type="checkbox"/> P Bad Breath |
| <input type="checkbox"/> C <input type="checkbox"/> P Weakness in Grip | <input type="checkbox"/> C <input type="checkbox"/> P Hearing Loss or Disturbance | <input type="checkbox"/> C <input type="checkbox"/> P Loss of Taste |
| <input type="checkbox"/> C <input type="checkbox"/> P Coldness in Hands | <input type="checkbox"/> C <input type="checkbox"/> P Ear Discharge | <input type="checkbox"/> C <input type="checkbox"/> P Loss of Touch Sensation |
| <input type="checkbox"/> C <input type="checkbox"/> P Eye Pain | <input type="checkbox"/> C <input type="checkbox"/> P Thyroid Conditions | <input type="checkbox"/> C <input type="checkbox"/> P Stroke or TIA |
| <input type="checkbox"/> C <input type="checkbox"/> P Visual Disturbances | <input type="checkbox"/> C <input type="checkbox"/> P Sinusitis | |

THORACIC SPINE (UPPER BACK):

Postural distortions from subluxations in the upper back will weaken the nerves to the heart and lungs and affect these parts of your body. Do you experience...?

- | | | |
|--|--|---|
| <input type="checkbox"/> C <input type="checkbox"/> P Chest Pain | <input type="checkbox"/> C <input type="checkbox"/> P Fatigue | <input type="checkbox"/> C <input type="checkbox"/> P Shortness of Breath |
| <input type="checkbox"/> C <input type="checkbox"/> P Heart Palpitations | <input type="checkbox"/> C <input type="checkbox"/> P Swelling in the Legs | <input type="checkbox"/> C <input type="checkbox"/> P Pain on Deep Inspiration/Expiration |
| <input type="checkbox"/> C <input type="checkbox"/> P Heart Murmurs | <input type="checkbox"/> C <input type="checkbox"/> P Changes in Skin Color | <input type="checkbox"/> C <input type="checkbox"/> P Frequent/Chronic Cough |
| <input type="checkbox"/> C <input type="checkbox"/> P Tachycardia | <input type="checkbox"/> C <input type="checkbox"/> P Heart Valve Problems | <input type="checkbox"/> C <input type="checkbox"/> P Phlegm/Expectorant |
| <input type="checkbox"/> C <input type="checkbox"/> P Heart Attacks/Angina | <input type="checkbox"/> C <input type="checkbox"/> P Recurrent Lung Infections/Bronchitis | <input type="checkbox"/> C <input type="checkbox"/> P Coughing up Blood (Hemoptosis) |
| <input type="checkbox"/> C <input type="checkbox"/> P Fainting | <input type="checkbox"/> C <input type="checkbox"/> P Asthma/Wheezing | <input type="checkbox"/> C <input type="checkbox"/> P Blue Skin (Cyanosis) |

THORACIC SPINE (MID BACK):

Postural distortions from subluxations in the mid back will weaken the nerves into your ribs/chest, urinary and upper digestive tract, and affect these parts of your body. Do you experience...?

- | | | |
|---|--|--|
| <input type="checkbox"/> C <input type="checkbox"/> P Mid Back Pain | <input type="checkbox"/> C <input type="checkbox"/> P Reflux | <input type="checkbox"/> C <input type="checkbox"/> P Bloating, Abdominal Distention |
| <input type="checkbox"/> C <input type="checkbox"/> P Pain into your Ribs/Chest | <input type="checkbox"/> C <input type="checkbox"/> P Nausea | <input type="checkbox"/> C <input type="checkbox"/> P Hypoglycemia |
| <input type="checkbox"/> C <input type="checkbox"/> P Abdominal Pain | <input type="checkbox"/> C <input type="checkbox"/> P Ulcers/Gastritis | <input type="checkbox"/> C <input type="checkbox"/> P Tired/Irritable after Eating or when you Haven't Eaten for a while |
| <input type="checkbox"/> C <input type="checkbox"/> P Indigestion/Heartburn | <input type="checkbox"/> C <input type="checkbox"/> P Cramping | |

LUMBAR SPINE (LOW BACK):

Postural distortions from subluxations in the low back will weaken the nerves into your legs/feet, lower digestive tract, urinary and pelvic organs and affect these parts of your body. Do you experience...?

- | | | |
|---|--|---|
| <input type="checkbox"/> C <input type="checkbox"/> P Low Back Pain | <input type="checkbox"/> C <input type="checkbox"/> P Constipation | <input type="checkbox"/> C <input type="checkbox"/> P Kidney Stones |
| <input type="checkbox"/> C <input type="checkbox"/> P Pain into your Hips/Legs/Feet | <input type="checkbox"/> C <input type="checkbox"/> P Diarrhea | <input type="checkbox"/> C <input type="checkbox"/> P Menstrual Irregularities/Cramping (females) |
| <input type="checkbox"/> C <input type="checkbox"/> P Numbness/Tingling in your Legs/Feet | <input type="checkbox"/> C <input type="checkbox"/> P Pain during Urination | <input type="checkbox"/> C <input type="checkbox"/> P Sexual Dysfunction |
| <input type="checkbox"/> C <input type="checkbox"/> P Coldness in your Legs/Feet | <input type="checkbox"/> C <input type="checkbox"/> P Recurrent Bladder Infections | <input type="checkbox"/> C <input type="checkbox"/> P Genital Itching |
| <input type="checkbox"/> C <input type="checkbox"/> P Muscle Cramps in your Legs/Feet | <input type="checkbox"/> C <input type="checkbox"/> P Change in Frequency of Urination | <input type="checkbox"/> C <input type="checkbox"/> P Rectal Bleeding |
| <input type="checkbox"/> C <input type="checkbox"/> P Weakness/Injuries in your Hips/Knees/Ankles | <input type="checkbox"/> C <input type="checkbox"/> P Change in Urine Flow | |
| | <input type="checkbox"/> C <input type="checkbox"/> P Change in Urine Color | |

CONFIDENTIAL PATIENT INFORMATION

Patient Name: _____

Date: _____

TERMS OF ACCEPTANCE

When a person seeks chiropractic and rehabilitation health care and is accepted for such care, it is essential for both parties to be working towards the same objective. Every patient at our clinic is given a choice in the care they receive because we believe health is a personal choice and each patient's circumstances are unique. All that we ask is that, if you accept our care program, you follow the doctor's recommendation because your results depend more on you than the doctor.

What Sets Us Apart?

We take a Patient centered approach focusing on results. Our Care includes more than conventional chiropractic care, we utilize a combination of the most advanced and newest chiropractic techniques and therapies available. Our focus in the clinical application of the Pettibon System™ in chiropractic care is to provide patients with the tools you need to strengthen and correct yourself. This permits us to achieve great changes in the body's global posture, disc height and health, and reduction of nerve irritation in a relatively short period of time—and therefore at less cost than conventional chiropractic. It is an extensively researched, viable alternative to physical therapy and in many cases surgery. Through meticulous evaluation and comparison to researched biomechanical norms, a global postural and spinal strengthening care plan is tailor-made for each patient, and is designed to restore, as closely as possible, your optimal spinal form and function. This ensures a decrease in related pain and symptoms, as well as, a greater ability to prevent spine, disc and nerve related issues. Our goal is achieved when you need to see us as little as possible.

Over this and the next several visits you will be learning more about our corrective care program and how it may benefit you.

CONSENT TO EXAMINATION AND CARE

I do hereby authorize the doctor(s) of Spine Re-New P.C. and any therapist(s) and chiropractic technician(s) working at the clinic to administer such care that is necessary for my particular case (or my child/dependant/ward's particular case). This care may include consultation, examination, spinal adjustments and other chiropractic procedures, including various modes of physical therapy, laser therapy and diagnostic x-rays or any other procedure that is advisable, and necessary for my health care.

I understand and have been informed that during the process of a thorough examination that my current symptoms/condition may be exacerbated due to the nature of the examination. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise clinical judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interests. The doctor will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions treated at this clinic. There are no guaranties or assurances concerning the intended results of the treatments.

I have had an opportunity to discuss with the doctor of chiropractic and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures related to my health care (or my child's/dependant's/Ward's health care). I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I understand and have been informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to fractures, disk injuries, dislocations, sprains, increased symptoms and pain, or no improvement of symptoms and pain. A rare but serious risk associated with neck manipulation is stroke. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise clinical judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. The doctor will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal and/or extremity structural conditions treated at this clinic. There are no guaranties or assurances concerning the intended results of the treatments.

I also clearly understand that if I do not follow the Doctors specific recommendations at this clinic, that I will not receive the full benefit from the programs offered, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the Doctor and/or this clinic for all services rendered. I also understand any sum of money paid under assignment by any insurance company shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the doctor.

I, _____, have read or have had read to me, the above consent to care. I have also had the opportunity to
(PRINT patient name or Parent/Guardian)

ask questions about the care, and my questions have been fully answered. By signing below, I consent to this treatment. I intend this consent form to cover the entire course of treatment for my (or my child/dependant/ward's) present condition and for any future conditions(s) for which I seek treatment.

Signature _____
(If under age 18 Parent's signature)

Date _____

CONFIDENTIAL PATIENT INFORMATION

Patient Name: _____

Date: _____

CONSENT TO X-RAY

Adult

I hereby authorize Spine Re-New P.C. and whomever the licensed doctor and whomever the doctor may designate as his/her assistant to take x-rays.

Females Only:

Onset of last menstrual period: Date: _____ Are you Pregnant? Yes No I don't know

Is there any chance that you may be pregnant? Yes No I have had a hysterectomy: Yes No

By signing below, I consent to the terms of acceptance, exam, treatment and x-rays

Patient signature: _____ Date: _____

Child

I hereby authorize Spine Re-New P.C. and whomever the licensed doctor and whomever the doctor may designate as his/her assistant to take x-rays of my child/dependant/ward.

Patient/child's name: _____

Parent or guardian signature: _____ Date: _____

Parent or guardian Name: _____
Please print

Office Financial Policy

It is our office policy that all services rendered are the responsibility of the patient, and that you are ultimately personally responsible for all payments regardless of whether or not this office accepts insurance assignment.

1. Patients without insurance: All payments are expected at the time of service or preset on a payment plan or program. Personal balances should not exceed \$150 at any time, unless on a prearranged payment plan.
2. Patients with insurance: Deductibles and all co-payments are expected at the time of service or preset on a payment plan. Your patient responsibility balance should not exceed \$150, unless on a prearranged payment plan.

It is the policy of this office to extend to our patients the courtesy of assigning your insurance benefits directly to us. We are happy to extend this credit to you so that you can follow through with all the care you may require. The following are important points of consideration to be aware of:

1. The privilege of insurance assignment begins when our office receives and verifies your insurance information.
2. As a courtesy to you our office will pre-qualify your insurance coverage. In an effort to help you determine what coverage is available to you under your policy. We will help you make the best estimate of your coverage for the recommend services. This service is a courtesy to you and is not a guarantee of coverage.
3. As a courtesy, this office will submit secondary insurance, if necessary.
4. If your insurance has not paid on an assigned bill within 60 days, you will be notified. Since we do not own your policy, we ask that you stay in communication with our office and take action with your insurance company at that time. If it remains unpaid within 90 days, the balance becomes due and payable immediately and your assignment is revoked.
5. All patients whose treatment visitation schedule is once per month or longer will no longer be eligible for insurance assignment as this level of care is rarely covered by insurance. Our office offers numerous wellness club plans to allow you to continue needed care.
6. No one can predict what an insurance company will pay for the usual and customary charges for services rendered. If we participate on your plan, you will not encounter balance billing above the stated fee schedule. If we do not participate, we will work with you to determine the amount of coverage and help estimate your responsibility.
7. Should you discontinue care for any reason, other than discharge by the doctor, any and all balances will become due and payable at that time. If you are on a predetermined payment plan, that plan will continue to be in effect until your balance is zero.
8. The goal of this office is to provide you with the finest quality Chiropractic care available. If you have any questions with regard to your health care or any of our policies, please let us know.

Signed: _____ Date: _____