STONE CHIROPRACTIC
Building A Healthy Foundation

PATIENT NAME:_____

PATIENT NO:_____

WELCOME

The doctors and staff of Stone Chiropractic welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care, we will not accept you as a patient but will refer you to another health care provider, if appropriate.

INSURANCE

This office will process your insurance forms upon request. We will do our utmost to provide sufficient information to your carrier to obtain payment for your treatment. We have found that, in some instances, however, insurance companies will deny or reduce payment despite our best efforts to demonstrate the necessity for care. In the event that full payment is not made for any reason, you must understand that you are responsible to make payment in full.

PATIENT IDENTIFICATION

Name
_____
Street
_____
City, State and Zip
_____

Social Security #_____
Male ( ) Female ( )

Date of Birth _____ Age _____
Occupation:_____

Contact in case of emergency
Name: _____
Telephone # _____

Name or Nickname I prefer to be called:
_____

Telephone:
(Home) _____
(Cell) _____
(Work) _____
(Email) _____

*To receive text reminders please list your cell phone carrier
Cell Company: _____

Preference(s) for Appointment Reminders:
( )Call ( )*Text ( )Email

___Married ___ S ___ W ___ D # of Children_____ Name of Spouse_____

Parent's Name if Minor Child Patient: _____

_____ _____
Name of Primary Policy Holder D.O.B. of Primary Policy Holder

_____ _____
Date Signature

Please fill out the following form in as much detail as possible.

Please print

Would you like to receive our e-newsletter containing the latest health tips? Y or N

Have you ever had chiropractic care before? _____

For what problem? _____

Were the results satisfactory? Yes_____ No_____ N/A_____

What brings you into the office today (please list your health challenge(s))?

_____

_____

Do you have any questions or chiropractic apprehensions before today's treatment?

_____

_____

Will this case be covered by any insurance company? Major Medical _____
Auto/PI _____Workers' Compensation _____ Medicare _____
Medicaid/BadgerCare _____
Other (Please list) _____

How did you find out about us? Times-Villager_____ Post Crescent_____
Magazine_____ Larry's Piggly Wiggly_____ Health Fair_____ Television_____
Cooking or Family Extravaganza_____Other (Please Specify)_____

ACCEPTANCE AS PATIENT

I understand and agree that the doctors of Stone Chiropractic have the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

_____ _____

Date Signature

STONE CHIROPRACTIC
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FINANCIAL POLICY

Thank you for choosing Stone Chiropractic for your chiropractic needs. We appreciate the opportunity to serve you and are committed to providing you with the best possible care. Please read and sign below.

It is the responsibility of the patient or responsible party to see that all charges are paid in full, even if the insurance pays less than the actual bill for services.
As a courtesy to you, we will file all medical claims, with the primary and secondary insurance. However you must provide us with current copies of your insurance and notify us immediately if there are changes in this information.

It is **your responsibility** to obtain any referrals required by your insurance company and update them as needed. If you do not have a current referral you may be asked to reschedule your appointment or sign a waiver stating that you will be responsible for payment of charges.

COPAYMENTS & CASH PAYMENTS (HMO, PPO) **ARE DUE AT TIME OF SERVICE**. We accept Cash, Check or Credit Card. Payments by check or exact change are appreciate

Cash Patient: If you do not have health insurance or choose to not use your health insurance, we offer a cash discount as a courtesy to you. Our discounted cash rates must be paid at the time of your visit.
If you can not pay at the time of service, normal rates will apply. For example, a normal adjustment code is offered at a $40 cash rate at time of service. If not paid at time of service, $50.00 is the normal rate.

Medicare Patients: We submit and accept Medicare claims. As a courtesy, we will file your secondary insurance.

No Insurance: If you do not have health insurance, a payment equaling **at least half** of the cost of your first visit will be collected at the time of your first visit. A $25.00 payment will be collected at time of each return visit. Any outstanding balance is due immediately upon receipt of statement.

Divorce: In divorce situations, the parent who brought the child in is responsible for payment of the bill. We submit to the necessary insurance carriers.

Contact Stone Chiropractic at 920-462-0912 if you have any questions regarding your account **before any payment is past due**.
Accounts that are **90 days past due** may be referred to a collection agency unless payment arrangements have been made. If you have a financial hardship please let us know so we can set up payment arrangements.
There will be a **$25.00 service charge** for any returned checks.
You have a contract with your insurance company---we do not. It is **your responsibility** to communicate with the insurance company if you are not happy with your insurance company's determination of benefits for your claim.

I have read and received a copy of the Financial Policy and understand its contents. I hereby assign all medical benefits (to include major medical, Medicare, private insurance and other health plans) to Stone Chiropractic, LLC. I also authorize Stone Chiropractic to release information regarding my chiropractic care to my insurance company to obtain payment.

X_____ X_____
Signature of Responsible Party **Relationship** to Patient

X_____ X_____
Print Name of Responsible Party Date

STONE CHIROPRACTIC
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Stone Chiropractic will charge a fee for any Chiropractic OR Massage no-shows.

In order to make sure that all patients needing care can be seen in a timely manner, **we charge a fee of $40.00 for a missed a chiropractic appointment and a fee of $35.00 for a missed massage therapy appointment.**

Any patient who does not attend their scheduled appointment and does NOT call within 24 hours notice is considered a no show.
So please note, if you need to reschedule or cancel your appointment for any reason, we ask that you do so at least twenty-four hours prior to your scheduled appointment.

In case of emergencies, please contact us as soon as you are able and we will work with you.

Any after hour or weekend appointments will cost an additional fee of $30.00.

This would be any appointment made after regular business hours and weekend appointments that are on a Saturday or Sunday.
This fee will have to be paid on the date of service.

We appreciate your understanding with these policies. If you have any questions or concerns, please let us know right away.

By signing this, you have approved of these policies and have addressed any concerns you may have with it with Stone Chiropractic Staff.

Print Name:_____ **Signature** _____ **Date**_____

STONE CHIROPRACTIC
Building A Healthy Foundation

PATIENT PRIVACY (HIPPA)

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name_____ Signature_____ Date_____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To our valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

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Patient Goals and Expectations:

Please check **one** of following, as it applies to *you*.

Your answer will in no way effect the level of treatment you receive. The sole purpose of this document is to inform your chiropractor of your personal goals and expectations to better serve you.

____ **Pain Relief -** My singular goal is relief of my pain symptoms. My only expectation is that the doctor of chiropractic will provide care to help alleviate these symptoms.

____ **Health Care -** My goal is to get back to the level I had before the symptoms began, and/or to maintain my current health. My expectation is for the doctor to provide care that will both reduce my symptoms and help regain my previous health state.

____ **Wellness -** My goal is to improve my overall health. My expectation is that the chiropractor will aid in designing a personal program for this improvement.

Patient Privacy (HIPPA)

I give my consent for the following people to receive/review my medical information, such as my medical records and appointment times:

Name:_____ Relationship:_____ Date Added:_____

Name:_____ Relationship:_____ Date Added:_____

Name:_____ Relationship:_____ Date Added:_____

Name:_____ Relationship:_____ Date Added:_____

I give my consent for messages to be left at my home, mobile, or work regarding appointment times and follow up information.

Print Name: _____ Signature:_____ Date:_____

STONE CHIROPRACTIC
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Case #:_____ Patient Name:_____

Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

REVIEW OF SYSTEMS – Please fill out all of the sections, even if "DENY".

Constitutional:

❑ Chills ❑ Daytime Somnolence (Drowsiness) ❑ Fatigue ❑ Fever ❑ Night Sweats
❑ Weight Gain ❑ Weight Loss
I… ❑ Deny Any Constitutional Issue (s)

Eyes/Vision:

❑ Blindness ❑ Blurred Vision ❑ Cataracts ❑ Change in vision ❑ Double Vision
❑ Eye Pain ❑ Field Cuts (visual field defect) ❑ Glaucoma ❑ Itching (around the eyes) ❑ Photophobia
❑ Tearing ❑ Wears Glasses and/or Contact lenses (Sensitive to Light)
I… ❑ Deny Any Eyes/Vision Issue (s)

Ears, Nose and Throat:

❑ Bleeding ❑ Dental Implants ❑ Dentures ❑ Difficulty Swallowing ❑ Discharge
❑ Dizziness ❑ Ear Drainage ❑ Ear Infection(s) ❑ Ear Pain ❑ Fainting
❑ Headaches ❑ Head Injury (history of) ❑ Hearing Loss ❑ Hoarseness ❑ Loss of Smell
❑ Nasal Congestion ❑ Nose bleeds (frequent) ❑ Post Nasal Drip ❑ Rhinorrhea (Runny nose) ❑ Sinus Infections
❑ Snoring ❑ Sore Throats (frequent) ❑ Tinnitus (Ringing in Ears) ❑ TMJ problems
I… ❑ Deny Any Ears, Nose and Throat Issue (s)

Respiration:

❑ Asthma ❑ Cough ❑ Coughing up blood ❑ Shortness of Breath ❑ Sputum Production ❑ Wheezing
I… ❑ Deny Any Respiratory Issue (s)

Cardiovascular:

❑ Angina (chest pain or discomfort) ❑ Chest Pain ❑ Claudication (leg pain or achiness) ❑ Heart Murmur
❑ Heart Problems ❑ Orthopnea (difficulty breathing while lying down) ❑ Palpitations (irregular or forceful beating of the heart)
❑ Paroxysmal Nocturnal Dyspnea (waking at night with shortness of breath) ❑ Shortness of Breath with Exertion or Exercise
❑ Swelling of Legs ❑ Ulcers ❑ Varicose Veins ❑ High Blood Pressure
I… ❑ Deny Any Cardiovascular Issue (s)

Gastrointestinal:

❑ Abdominal Pain ❑ Belching ❑ Black, Tarry Stools ❑ Constipation ❑ Diarrhea
❑ Difficulty Swallowing ❑ Heartburn ❑ Hemorrhoids ❑ Indigestion ❑ Jaundice (yellowing of the skin)
❑ Nausea ❑ Rectal Bleeding ❑ Abnormal Stool Caliber (quality) ❑ Abnormal Stool Color
❑ Abnormal Stool Consistency ❑ Vomiting ❑ Vomiting Blood
I… ❑ Deny Any Gastrointestinal Issue (s)

Female:

❑ Birth Control Therapy ❑ Breast Lumps/Pain ❑ Burning Urination ❑ Cramps ❑ Frequent Urination
❑ Hormone Therapy ❑ Irregular Menstruation ❑ Urine Retention ❑ Vaginal Bleeding ❑ Vaginal Discharge
I… ❑ Deny Any Female Issue (s)

Male:

❑ Burning Urination ❑ Erectile Dysfunction ❑ Frequent Urination ❑ Hesitancy/Dribbling ❑ Prostate Problems

❑ Urine Retention
I… ❑ Deny Any Male Issue (s)

Signature:_____ Date:_____

Endocrine:
❑ Cold Intolerance ❑ Diabetes ❑ Excessive Appetite ❑ Excessive Hunger ❑ Excessive Thirst
❑ Frequent Urination ❑ Goiter ❑ Hair Loss ❑ Heat Intolerance ❑ Unusual Hair Growth
❑ Voice Changes
I… ❑ Deny Any Endocrine Issue (s)

Skin:
❑ Changes in Nail Texture ❑ Changes in Skin Color ❑ Hair Growth ❑ Hair Loss ❑ Hives ❑ Itching
❑ Paresthesia (numbness, prickling, or tingling) ❑ Rash ❑ History of Skin Disorders ❑ Skin Lesions/Ulcers ❑ Varicosities
I… ❑ Deny Any Skin Issue (s)

Nervous System:
❑ Dizziness ❑ Facial Weakness ❑ Headaches ❑ Limb Weakness ❑ Loss of Consciousness
❑ Loss of Memory ❑ Numbness ❑ Seizures ❑ Sleep Disturbance ❑ Slurred Speech
❑ Stress ❑ Strokes ❑ Tremors ❑ Unsteadiness of Gait
I… ❑ Deny Any Nervous System Issue (s)

Psychologic:
❑ Anhedonia (inability to experience joy or enjoy life) ❑ Anxiety ❑ Appetite Changes ❑ Behavioral Change(s)
❑ Bipolar Disorder ❑ Confusion ❑ Convulsions ❑ Depression ❑ Insomnia ❑ Memory Loss
❑ Mood Change(s)
I… ❑ Deny Any Psychologic Issue (s)

Allergy:
❑ Anaphylaxis (history of) ❑ Food Intolerance ❑ Itching ❑ Nasal Congestion ❑ Sneezing
I… ❑ Deny Any Allergy Issue (s)

Hematology:
❑ Anemia ❑ Bleeding ❑ Blood Clotting ❑ Blood Transfusion(s) ❑ Bruises easily ❑ Fatigue ❑ Lymph Node Swelling
I… ❑ Deny Any Hematologic Issue (s)

PAST HEALTH HISTORY – Please fill out carefully as these problems can affect your overall course of care.

Childhood Illness:
❑ ADD ❑ Allergies/Hayfever ❑ Asthma ❑ Atopic Dermatitis (Eczema) ❑ Bedwetting
❑ Cerebral Palsy ❑ Chicken Pox ❑ Depression ❑ Diabetes ❑ Ear Infections
❑ Fetal Drug Exposure ❑ Food Allergies ❑ Headaches ❑ Hepatitis ❑ HIV
❑ Measles ❑ Mumps ❑ Rash ❑ Scoliosis ❑ Seizure Disorder
❑ Sickle Cell Anemia ❑ Spina Bifida ❑ Other (please describe): _____
I… ❑ Deny Any Childhood Illness (es)

Adult Illness:
❑ Alzheimer's ❑ Anemia ❑ Arthritis ❑ Asthma ❑ Cancer
❑ Chicken Pox ❑ Crohn's/Colitis ❑ CRPS (RSD) ❑ CVA (stroke) ❑ Cystic Kidney Disease
❑ Depression ❑ Diabetes (Insulin) ❑ Diabetes (Non insulin) ❑ Ear Infections (frequent) ❑ Emphysema
❑ E ye Problems ❑ Fibromyalgia ❑ Heart Disease ❑ Hepatitis ❑ HIV
❑ Hypertension ❑ Influenzal Pneumonia ❑ Liver Disease ❑ Lung Disease ❑ Lupus Erythema (discoid)
❑ Lupus Erythema (systemic) ❑ Multiple Sclerosis ❑ Parkinson's Disease ❑ Pleurisy ❑ Pneumonia
❑ Psychiatric Problems ❑ Scoliosis ❑ Seizure Disorder ❑ Shingles ❑ STD's (unspecified)
❑ Suicide Attempt(s) ❑ Thyroid Problems ❑ Vertigo
❑ Past history of similar symptoms to your current condition ❑ Other Illness (please be specific): _____
I… ❑ Deny Any Adult Illness (es)

Surgeries:

❑ Angioplasty ❑ Appendectomy ❑ Caesarian Section ❑ Cardiac Catheterization ❑ Carpal Tunnel Repair
❑ Coronary Artery Bypass ❑ Cosmetic ❑ D & C ❑ Dental Surgery ❑ Gallbladder
❑ Hemorrhoidectomy ❑ Hernia Repair ❑ Hysterectomy ❑ Joint Reconstruction ❑ Joint Replacement
❑ Laminectomy ❑ Mastectomy ❑ Pacemaker Insertion ❑ Rotator Cuff ❑ Spinal Fusion
❑ Tonsilectomy ❑ Other (please be specific): _____ _I… ❑ Deny Any Surgery (ies)

Signature:_____**Date:**_____

Ob/Gyn:

I… ❑ have never been pregnant ❑ have been pregnant in the past ❑ am currently pregnant
_____ Number of pregnancies _____ Number of complicated pregnancies _____ Number of uncomplicated pregnancies
_____ Number of miscarriages _____ Number of terminated pregnancies _____ Number of Epidural Injections
_____ Number of C-Sections _____ Number of vaginal deliveries
I… ❑ Deny Any Ob/Gyn Issue (s)

Menstrual History: Age of Onset _____
My menses is ❑ Regular ❑ Irregular; I am currently in ❑ Metaphase ❑ Menopause; Date of Last Menses _____/_____/_____

Injuries:

❑ Back Injury ❑ Broken Bones ❑ Severe Fall ❑ Fracture ❑ Disability
❑ Head Injury ❑ Industrial Accident ❑ Joint Injury ❑ Severe Laceration ❑ Motor Vehicle Accident
❑ Mild/Moderate Soft Tissue Injury ❑ Severe Soft Tissue Injury
I… ❑ Deny Any Injury (ies)

Immunizations:

❑ DTaP(diptheria, tetanus, and pertussis) ❑ Flu ❑ Hepatitis A ❑ Hepatitis B ❑ Hepatitis C
❑ Influenza ❑ IPV (Polio) ❑ MMR (measles, mumps, and rubella) ❑ Pneumococcal
❑ PPD (Mantoux Test-TB) ❑ Small Pox ❑ TB ❑ Varivax (chicken pox) ❑ Covid-19
❑ WhoopingCough (Pertussis)
I… ❑ Deny Any Immunization (s)

Non-Drug Allergies:

❑ Animals ❑ Dairy ❑ Eggs ❑ Food Coloring ❑ Mold ❑ Pollen ❑ Wheat
❑ Other (please be specific): _____
I… ❑ Deny Any Non-Drug Allergy (ies)

Family History

		Condition (please be specific)
General Family	❑ Alive	❑ Deceased; ❑ No Significant Disease ❑ Has/Had: _____
Father	❑ Alive	❑ Deceased; ❑ No Significant Disease ❑ Has/Had: _____
Mother	❑ Alive	❑Deceased; ❑No Significant Disease ❑Has/Had: _____
Paternal Grandfather	❑ Alive	❑ Deceased; ❑ No Significant Disease ❑ Has/Had: _____
Paternal Grandmother	❑ Alive	❑ Deceased; ❑ No Significant Disease ❑ Has/Had: _____
Maternal Grandfather	❑ Alive	❑ Deceased; ❑ No Significant Disease ❑ Has/Had: _____
Maternal Grandmother	❑ Alive	❑ Deceased; ❑ No Significant Disease ❑ Has/Had: _____
Son (s)	❑ Alive	❑ Deceased; ❑ Normally Developed ❑No Significant Disease ❑Has/Had: _____
Daughter (s)	❑ Alive	❑ Deceased; ❑ Normally Developed❑ No Significant Disease❑Has/Had_____
Brother (s)	❑ Alive	❑ Deceased; ❑ Normally Developed ❑No Significant Disease ❑ Has/Had: _____
Sister (s)	❑ Alive	❑ Deceased; ❑ Normally Developed ❑ No Significant Disease ❑ Has/Had: _____

Social History

Alcohol: ❑ Never ❑ Social Consumption only ❑ Beer ❑ Liquor ❑ Wine ; _____ oz ____ glasses; ❑ Day ❑ Week ❑ Month
Diet (please mark all that apply): ❑ High Fat ❑ High Fiber ❑ High Protein ❑ High Salt ❑ Low Sugar
❑ Low Calorie ❑ Low Carb ❑ Low Fiber ❑Low Salt ❑ Other:_____

Education (please mark the highest level completed): ❑ Preschool ❑ Elementary ❑ Middle ❑ Junior High ❑ Votech
❑ In High School ❑ Did Not Finish High School ❑ High School Diploma ❑ Post High School Classes❑ Assoc/Technical Degree
❑ In College ❑ College Degree ❑ In Graduate School ❑ Graduate Degree ❑ Doctorate ❑ Other: _____

Drugs: ❑ **Deny any illegal drug use** ❑ **Deny use of IV drugs** ❑ **Have not used drugs since _____** ❑ **Have used drugs for _____**
Tobacco: ❑ **Deny Tobacco Use** ❑ **Do not smoke cigars, cigarettes or pipe** ❑ **Live with a smoker** ❑ **Quit smoking**
❑ **Smoke; # _____ per** ❑ **Day** ❑ **Week** ❑ **Month** ❑ **Chew; #_____cans per** ❑ **Day** ❑ **Week** ❑ **Year**

Current Medications:_____

Current Supplements: _____

Patient Signature_____ Date_____

SC STONE CHIROPRACTIC
Building A Healthy Foundation

Medical doctors, chiropractic doctors, osteopaths, and physical therapists that perform manipulations are required by law to obtain your informed consent before starting treatment.

I _____, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness: I am aware that like exercise it is common to experience muscle soreness in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments. Once in a

million is about the same chance as getting hit by lightening. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor.

Tests have been performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

Treatment Results

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.

I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

Alternative Treatments Available

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may

mask pathology, produce inadequate or short-term relief, undesirable side-effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bed-rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint stability or serious disk rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increases pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

_____ Signature of patient

_____ Signature of witness

_____ Date

PATIENT STATUS AT TIME OF INFORMED CONSENT PROCESS

Based on my personal observations, medical history and direct conversation with the patient, I conclude that throughout the consent process the patient was:

[ ] Of legal age
[ ] Oriented x 3
[ ] Disoriented as to
[ ] Coherent and lucid
[ ] On prescription/OTC medication but unimpaired
[ ] Proficient in understanding the English language
[ ] Assisted in understanding by an interpreter

(Interpreter's name:_____)

[ ] Resolute in denying the use of alcohol and or recreational drug use prior to consent
[ ] Unable to give legal consent
[ ] Consent given thru legal guardian

_____ _____

Name Relationship

Patient's questions (if any) and information supplied are as follows:

_____

_____

_____

_____

_____

Comments: _____

I certify that the above accurately describes the above named patient's status during the informed consent process.

_____ _____

Date Signature of Doctor

Website Membership Enrollment

The information on our website will help you

Get Well and Stay Well.



Please provide the following details so we can establish you as a member of our website today:

First name: _____

Last name: _____

Date of birth: _____ / _____ / _____

Email address: _____

Please check the health subjects that most interest you:

- ❑ Headaches and Neck Pain
- ❑ Backaches and Sciatica
- ❑ Children's Health Issues
- ❑ Exercise and Fitness
- ❑ Diet and Nutrition
- ❑ Stress Management
- ❑ Wellness Topics
- ❑ Women's Health Issues

By joining our website, you authorize us to send occasional health care related emails to you. Naturally, you may opt-out at any time. Please review our complete privacy policy on our website.

Lifecycle:	
Chiropractor:	