FELD FAMILY CHIROPRACTIC CENTER
126 WEST MAIN STREET, ROCKAWAY NJ 07866
INFORMATION/APPLICATION FOR CARE

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. PLEASE PRINT.

Today's Date _____

Name _____ Home Phone _____ Work Phone _____

Cell Phone _____ E-Mail Address _____

Address _____ City _____ State ____ Zip _____

Age _____ Birth date _____ Marital Status: S M W D Number of Children _____

Your Employer _____ Occupation _____ Years on Job ____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____Your Social Security # _____

Do you have Medicare? Yes ____ No ____ Do you have Medicaid? Yes ____ No ____

Name of Spouse or Parent _____ Their birthdate _____

Spouse Employed By _____ Occupation _____Years On Job ____

Employer Address _____ City _____ State _____ Zip _____

Office Phone # _____ Spouse's SS# _____

Driver's License # _____ Referred to our office by: _____

Does your spouse have health insurance at work? Yes ____ No ____

How payment will be made: ___ Cash ___Credit Card ___Check

Type of Insurance: ___Health Insurance ___ Worker's Comp. ___Automobile Insurance Policy

Is your condition due to an accident? Yes ___ No ___ Date of accident?_____

Type of accident? Auto _____ Work/On Job _____ At Home _____ Other _____

Have you ever been in an auto accident? Past Year ___Past 5 Years ___Over 5 Years ___Never ____

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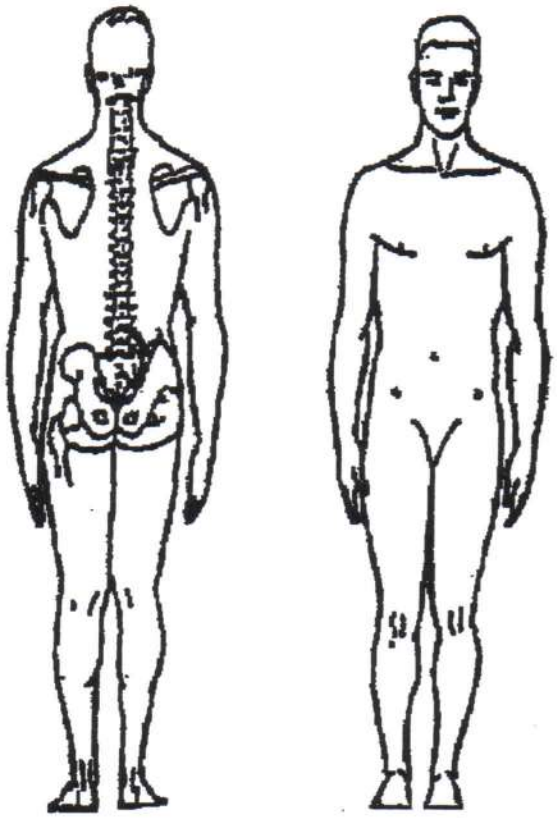
COMPLETE THESE DIAGRAMS

If you are in pain, please mark the exact location of your pain on the diagram. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example; dull, sharp, consistent, off & on, when standing, when sitting, etc.



MAJOR COMPLAINTS

(Please list any condition you are being treated for or are experiencing.) _____

_____

_____

_____

_____

_____

_____

MEDICATIONS

(Please list any medications you are currently taking.)

_____

_____

_____

_____

_____

_____

_____

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable.

Patient's Signature _____ Date _____

Or Guardian Signature _____ Date _____

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.

Insurance cases: On all insurance assignments, the deductible should be met in the beginning unless prior arrangements are made.

FELD FAMILY CHIROPRACTIC CENTER
Confidential Patient Case History

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Name _____ Date _____

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

O – OCCASIONAL F – FREQUENT C – CONSTANT

O	F	C	
			GENERAL
☐	☐	☐	Allergy
☐	☐	☐	Chills
☐	☐	☐	Convulsions
☐	☐	☐	Dizziness
☐	☐	☐	Fainting
☐	☐	☐	Fatigue
☐	☐	☐	Fever
☐	☐	☐	Headache
☐	☐	☐	Loss of sleep
☐	☐	☐	Loss of weight
☐	☐	☐	Nervousness/depression
☐	☐	☐	Neuralgia
☐	☐	☐	Numbness
☐	☐	☐	Sweats
☐	☐	☐	Tremors
			MUSCLE & JOINT
☐	☐	☐	Arthritis
☐	☐	☐	Bursitis
☐	☐	☐	Foot trouble
☐	☐	☐	Hernia
☐	☐	☐	Low back pain
☐	☐	☐	Lumbago
☐	☐	☐	Neck pain or stiffness
☐	☐	☐	Pain between shoulders
			Pain or numbness in:
☐	☐	☐	Shoulders
☐	☐	☐	Arms
☐	☐	☐	Elbows
☐	☐	☐	Hands
☐	☐	☐	Hips
☐	☐	☐	Legs
☐	☐	☐	Knees
☐	☐	☐	Feet
☐	☐	☐	Painful tail bone
☐	☐	☐	Poor posture
☐	☐	☐	Sciatica
☐	☐	☐	Spinal Curvature
☐	☐	☐	Swollen joints

O	F	C	
			GASTRO-INTESTINAL
☐	☐	☐	Belching or gas
☐	☐	☐	Colitis
☐	☐	☐	Colon trouble
☐	☐	☐	Constipation
☐	☐	☐	Diarrhea
☐	☐	☐	Difficult digestion
☐	☐	☐	Distension of abdomen
☐	☐	☐	Excessive hunger
☐	☐	☐	Gall bladder trouble
☐	☐	☐	Hemorrhoids
☐	☐	☐	Intestinal worms
☐	☐	☐	Jaundice
☐	☐	☐	Liver trouble
☐	☐	☐	Nausea
☐	☐	☐	Pain over stomach
☐	☐	☐	Poor appetite
☐	☐	☐	Vomiting
☐	☐	☐	Vomiting of blood
			EYES, EARS, NOSE &THROAT
☐	☐	☐	Asthma
☐	☐	☐	Colds
☐	☐	☐	Crossed eyes
☐	☐	☐	Deafness
☐	☐	☐	Dental Decay
☐	☐	☐	Earache
☐	☐	☐	Ear discharge
☐	☐	☐	Ear noises
☐	☐	☐	Enlarged glands
☐	☐	☐	Enlarged thyroid
☐	☐	☐	Eye pain
☐	☐	☐	Failing vision
☐	☐	☐	Far sightedness
☐	☐	☐	Gum trouble
☐	☐	☐	Hay fever
☐	☐	☐	Hoarseness
☐	☐	☐	Nasal obstruction
☐	☐	☐	Near sightedness
☐	☐	☐	Nosebleeds
☐	☐	☐	Sinus infection
☐	☐	☐	Sore throat
☐	☐	☐	Tonsillitis

O	F	C	
			CARDIO-VASCULAR
☐	☐	☐	Hardening of arteries
☐	☐	☐	High blood pressure
☐	☐	☐	Low blood pressure
☐	☐	☐	Pain over heart
☐	☐	☐	Poor circulation
☐	☐	☐	Rapid heart beat
☐	☐	☐	Slow heart beat
☐	☐	☐	Swelling of ankles
			RESPIRATORY
☐	☐	☐	Chest pain
☐	☐	☐	Chronic cough
☐	☐	☐	Difficult breathing
☐	☐	☐	Spitting up blood
☐	☐	☐	Spitting up phlegm
☐	☐	☐	Wheezing
			SKIN
☐	☐	☐	Boils
☐	☐	☐	Bruise easily
☐	☐	☐	Dryness
☐	☐	☐	Hives or allergy
☐	☐	☐	Itching
☐	☐	☐	Skin eruptions (rash)
☐	☐	☐	Varicose veins
			GENITO-URINARY
☐	☐	☐	Bed-wetting
☐	☐	☐	Blood in urine
☐	☐	☐	Frequent urination
☐	☐	☐	Inability to control kidneys
☐	☐	☐	Kidney infection or stones
☐	☐	☐	Painful urination
☐	☐	☐	Prostate trouble
☐	☐	☐	Pus in urine
			FOR WOMEN ONLY
☐	☐	☐	Congested breasts
☐	☐	☐	Cramps or backache
☐	☐	☐	Excessive menstrual flow
☐	☐	☐	Hot flashes
☐	☐	☐	Irregular cycle
☐	☐	☐	Menopausal symptoms
☐	☐	☐	Painful menstruation
☐	☐	☐	Vaginal discharge

☐ Yes ☐ No Are you pregnant?

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

☐ Alcoholism	☐ Cold sores	☐ Goiter	☐ Miscarriage	☐ Scarlet fever
☐ Anemia	☐ Diabetes	☐ Gout	☐ Multiple sclerosis	☐ Stroke
☐ Appendicitis	☐ Diphtheria	☐ Heart disease	☐ Mumps	☐ Tuberculosis
☐ Arteriosclerosis	☐ Eczema	☐ Influenza	☐ Pleurisy	☐ Typhoid fever
☐ Arthritis	☐ Emphysema	☐ Lumbago	☐ Pneumonia	☐ Ulcers
☐ Cancer	☐ Epilepsy	☐ Malaria	☐ Polio	☐ Venereal disease
☐ Chorea	☐ Fever blisters	☐ Measles	☐ Rheumatic fever	☐ Whooping cough

List surgical operation and years: _____

_____

Age of mattress: _____ ☐ Comfortable ☐ Uncomfortable ☐ Do you use a bed board? _____

Are you wearing: ☐ Heel lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports

Have you ever had any mental or emotional disorders? ☐ Yes ☐ No When? _____

Have others in your family had such disorders? ☐ Yes ☐ No When? _____

HAVE YOU EVER:	Yes	No	DESCRIBE BRIEFLY
Been knocked unconscious?	☐	☐	_____
Used a cane, crutch, or other support?	☐	☐	_____
Been treated for a spine or nerve disorder?	☐	☐	_____
Had a fractured bone?	☐	☐	_____
Been hospitalized for anything other than surgery?	☐	☐	_____
DO YOU:			
Now take vitamins or minerals?	☐	☐	_____
Think you may need vitamins or minerals?	☐	☐	_____
Have an allergy to any drug?	☐	☐	_____

DATE OF LAST:	Less than 6 months	6-18 months	Over 18 months	Never
Spinal examination	☐	☐	☐	☐
Physical examination	☐	☐	☐	☐
Blood test	☐	☐	☐	☐
Chest X- ray	☐	☐	☐	☐
Spinal X-ray	☐	☐	☐	☐
Dental X-ray	☐	☐	☐	☐
Urine test	☐	☐	☐	☐

HABITS	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

IN CASE OF EMERGENCY: (Name of relative or close friend **not living in your home**):

NAME _____ RELATIONSHIP _____

ADDRESS: _____

PHONE: _____

126 WEST MAIN STREET
ROCKAWAY NJ 07866
973-625-2099

FELD FAMILY CHIROPRACTIC CENTER

126 W. MAIN STREET

ROCKAWAY, NJ 07866

ELECTRONIC HEALTH RECORDS INTAKE FORM

IN COMPLIANCE WITH REQUIREMENTS FOR THE GOVERNMENT EHR INCENTIVE PROGRAM

DATE _____

NAME _____ HOME PHONE _____ CELL _____

ADDRESS_____ CITY _____ STATE_____ ZIP _____

AGE _____ BIRTH DATE _____ MARITAL STATUS (CIRCLE ONE) S M W D

GENDER (CIRCLE ONE) M F PREFERRED LANGUAGE _____

(CM5 REQUIRES PROVIDERS TO REPORT BOTH RACE AND ETHNICITY)

RACE (CIRCLE ONE) AMERICAN INDIAN / ALASKA NATIVE / ASIAN / AFRICAN AMERICAN / BLACK / WHITE (CAUCASIAN) / NATIVE HAWAIAN/PACIFIC ISLANDER / OTHER _____ / LATINO / DECLINE TO ANSWER

ETHNICITY: (CIRCLE ONE) HISPANIC OR LATINO / NOT HISPANIC OR LATINO / OTHER _____/

I DECLINE TO ANSWER

HEIGHT _____ WEIGHT _____ DATE OF LAST PHYSICAL EXAM _____

NAME OF PRIMARY CARE PHYSICIAN _____ PHONE # _____

ADDRESS_____ CITY _____ STATE_____ ZIP _____

ARE YOU CURRENTLY TAKING ANY MEDICATION? (PLEASE INCLUDE REGULARLY USED OVER THE COUNTER MEDICATIONS)

NAME OF MEDICATION/DATE OF FIRST DOSAGE	DOSAGE AND FREQUENCY (I.E. 5 MG ONCE A DAY, ETC)

DO YOU HAVE ANY MEDICATION ALLERGIES:

MEDICATION NAME	REACTION	ONSET DATE	ADDITIONAL COMMENTS

LIST ANY OTHER ALLERGIES: (I.E. HAYFEVER, ETC) _____

LIST ALL SURGERIES AND DATE OF SURGERY _____

_____

SMOKING STATUS: (CIRCLE ONE) EVERYDAY OCCASIONAL FORMER NEVER HOW MANY PACKS A DAY _____

☐ I DECLINE TO REQUEST RECEIPT OF MY CLINICAL SUMMARY AFTER EVERY VISIT. (THESE SUMMARIES ARE OFTEN BLANK AS A RESULT OF THE NATURE AND FREQUENTCY OF CHIROPRACTIC CARE.)

PATIENT SIGNATURE _____ DATE _____

FELD FAMILY CHIROPRACTIC CENTER
126 W. Main Street, Rockaway NJ 07866
PH: 973-625-2099 Fax: 973-625-2692
Michael Feld, D.C.

AUTHORIZATION, ASSIGNMENT & RELEASE FORM

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges Incurred.

2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney out of the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or you, based in whole or in part upon the charges made for your services.

3. In the event any insurance company obligated, by contractual agreement, to make payment to me or to you for the charges made for your services, refuses to make such payment upon demand by you. I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent date) and authorize you to prosecute and take action in my name as you see fit and further authorize you to compromise, settle or otherwise receive and claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed directly from me. I understand that whatever amounts you do not collect from the insurance companies' proceeds, whether it is all or part of what is due, I personally owe and agree to pay to you.

4. In addition to the above, I herby waive the statute of limitations on collection and/or recovery in this State of New Jersey

5. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.

6. This Authorization and Assignment will be in continual effect until revoked by both parties.

_____ _____
Patient/Insured Signature Date

RECORDS RELEASE

To _____, I hereby authorize you to release to Dr. Michael Feld any information including the diagnosis and records of treatment or examination rendered to me for all care during the period from _____ to _____.

_____ _____ _____ _____
Date Patient/Insured Signature Date Staff Signature

_____ Patient's date of birth: _____.
Print Patient Name

RELEASE FROM CARE

I, _____ hereby understand that Dr. Michael Feld is releasing me from care, for my accident dated _____, and that I have reached [ ] pre-accident status or [ ] maximum medical improvement. I further understand that all expenses incurred from this accident are my responsibility or the insurance company's and that all expenses incurred after the date below will be my personal responsibility. I will make financial arrangements for payment directly.

Patient Signature _____ Date_____ Staff Signature _____

FELD FAMILY CHIROPRACTIC CENTER

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED & DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Feld Family Chiropractic Center we may use or disclose personal and health related information about you in the following ways:

- Your personal health information , including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis assessment or treatment
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, PPO or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, phone number, email address and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine/voice mail. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- If we are providing health care services to you based on the orders of another health care provider
- If we provide health care services to you in an emergency
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written request.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient files and health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on the privacy notice may be subject to re-disclosure by the person to whom we provided the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities or would like further information about our privacy policies and practices please contact Dr. Michael Feld.

This notice is effective as of April 14, 2003. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received of copy of this notice.

Name (Please Print)	Signature	Date

If you are a minor, or if you are being represented by another party:

Name (Please Print)	Signature	Date

126 W MAIN STREET
ROCKAWAY NJ 07866
973-625-2099

FELD FAMILY CHIROPRACTIC CENTER

Patient authorization regarding chiropractic care being provided in an "open-door" adjusting environment

It is the desire of this office to provide chiropractic care in an "open-door" adjusting environment. An "open-door" approach involves the doctor moving from patient care area to patient care area and leaving the doors between patient care areas open. As a result patients are occasionally within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is **NOT** the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an "incidental disclosures" of health information. It is our view that the kinds of matters related in an "open-door" environment are incidental maters, in the event you or someone else would not agree with us we are providing this disclosure and requesting your authorization.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care. If you choose not to be adjusted in an "open-door" adjusting environment, other arrangements will be made for you. Your decision will have no adverse effect on your care from Feld Family Chiropractic Center or on your relationship with our staff.

Patient authorization for appointment reminders and scheduling related matters

It is our desire for our staff to use your name, address, email address and/or telephone number for the purpose of contacting you to remind you about scheduled appointments, re-evaluations or other appointment related issues.

The use of this information is intended to make your experience with our office more efficient and productive. If you choose not to authorize this information, your decision will have no adverse effect on your care from Feld Family Chiropractic Center or on your relationship with our staff.

The Use of "Thank you for referring a patient to our office" boards inside our office

Your signature indicates your authorization of these activities

Name (Printed) _____ Signature _____ Date _____

126 W MAIN STREET
ROCKAWAY NJ 07866
973-625-2099

DR. MICHAEL L. FELD
126 West Main Street
Rockaway, NJ 07866
Telephone: (973) 625-2099

Terms of Acceptance

When a patient seeks Chiropractic care, and when a Chiropractor accepts a patient for such care, it is essential that they both are seeking and working for the same goals.

Chiropractic has only one goal. It is therefore, important that the patient understands the goal and the means that will be used to attain it. In this way, there will be no confusion, misunderstanding or disappointment.

Patients usually want to get rid of whatever ailments or conditions are bothering them. This, however, is not the goal of the Chiropractor.

The purpose of Chiropractic is to restore and maintain the mechanical integrity of the spinal cord and its nerve roots. These vital nerve pathways are housed in and protected by the bones of the spine which interfere with the function of these nerve pathways are called subluxations. They come from many causes and prevent various organs and glands from working properly.

By means of a Chiropractic adjustment subluxations are corrected, thus restoring normal nerve function. The goal of Chiropractic is to correct vertebral subluxations for the purpose of restoring the proper transmission of nerve energy over the nerve pathways, so that every part of the body may have a proper nerve supply at all times. This allows the innate healing ability of the body to work at maximum efficiency.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

With a proper nerve supply health improves. Often, symptoms clear up; sometimes quickly, sometimes slowly, sometimes only partially, or not al tall. Regardless of what disease a patient may or may not have, a Chiropractor does not offer to cure it, treat it, or offer advice regarding it. The only goal of Chiropractic is to allow the body to better express its own innate health potential. The only method used is the correction of vertebral subluxations.

_____ _____ _____
Print Name Signature Date

Consent to evaluate and adjust a minor child:
I, _____ being the parent or legal guardian of _____
have read and fully understand the above Terms of Acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:
This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

_____ _____
Signature Date

FELD FAMILY CHIRPROACTIC CENTER

OFFICE FINANCIAL POLICY

CASH

1. All patients are on a cash basis until their respective insurance coverage and deductible may be verified by our staff.

2. This office may make payment plan arrangements on an individual basis. Any such plan or arrangement will be discussed during your report of findings.

INSURANCE

1. If you have insurance, we will gladly accept assignment with the following exceptions and regulations, provided we have prior certification from your insurance company.

2. We accept assignment for the initial treatment plan only. Any follow-up visits will be payable when services are rendered. Once you have been discharged from active care and placed on maintenance care, we will continue to file your insurance but require full payment per visit.

3. We accept assignment as a courtesy to you; you are responsible for your entire bill should your insurance company not pay any of the anticipated charges for any reason. We are not a mediator between you and your insurance company and will not enter into any dispute with the same, as your contract is between you and your insurance company.

4. Whenever you receive any worksheets from your insurance company or explanation of benefits, please bring this information into this office as soon as possible. We must have a copy of this to determine whether proper payment has been made. If you should receive a check from your insurance company during our billing, you must bring it into the office upon receipt. If any over-payment exists after all insurance billing has been done, we will issue you an overpayment check - it will not come from your insurance company. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due.

5. Any services not covered or coverage reductions by your insurance will be the patient's responsibility.

126 W. MAIN STREET
ROCKAWAY NJ 07866
973-625-2099

FELD FAMILY CHIRPROACTIC CENTER

6. This office will resubmit a claim ONE TIME. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster, or agent. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges on a timely basis.

7. If the patient is referred to another specialist or discontinues care for any reason other than discharge by the doctor, the bill is due and payment in full expected immediately; regardless of any claims submitted.

8. If you have questions concerning this or any other matter, please speak with the receptionist or our insurance department prior to seeing the Doctor.

Thank you.

I have read and understand the Financial Office Policy and agree to abide by these terms.

_____ _____

Patient's Signature Date

126 W. MAIN STREET
ROCKAWAY NJ 07866
973-625-2099

FELD FAMILY CHIROPRACTIC CENTER
CONSENT FOR TREATMENT AND AUTHORIZATION TO PERFORM X-RAYS

Date _____ Time _____ AM / PM

I have been informed by Dr. Feld that diagnostic x-rays are advisable in my case so that a complete analysis can be made of my present musculoskeletal problem (or illness).

I authorize Dr. Michael Feld to perform such radiographic examination necessary to diagnose, and to administer whatever treatment is deemed necessary to treat my present problem (or illness).

Signed: _____

Witness: _____

To the best of my knowledge I am NOT pregnant and the above named Doctor has my permission to x-ray me for diagnostic interpretation.

Signed: _____

Michael Feld, D.C.
126 W. Main Street
Rockaway NJ 07866
973-625-2099