A Chiropractic Healing

Please complete all questions. If you need help, please ask us for assistance.

Full Name: _____
Date of Birth: _____/_____/_____ Sex: ❑Male ❑Female SS#: _____

Email address: _____

Mailing Address: _____

_____

Phone #: _____ Are you currently pregnant? ❑Yes ❑No

Occupation: _____

Which wonderful person referred you to our office? _____

Last Chiropractic visit: _____

Emergency contact:
Name and Phone Number _____

Is this visit due to an accident? ❑ Yes ❑ No If yes, what type? ❑Auto ❑Work ❑Other

Date of Accident_____/_____/_____

I authorize consent to be contacted by A Chiropractic Healing (the "facility") and/or its providers. **I authorize the release** of any medical information, protected health information, and any other information necessary for billing, debt collection, to process claim(s), or any other related or similar purpose(s).

I authorize to have payment(s) of medical/healthcare benefits paid directly to the facility/physician/supplier for services. **I agree to pay for services** rendered as charge(s) are incurred. I understand and agree that insurance policies are an arrangement between an insurance carrier and me and I am personally responsible for payment of all services rendered or non-covered. If I suspend, terminate, or discontinue my care/treatment, the fees for services rendered will be immediately due and payable. I understand that if unpaid balance(s) exist on my account after attempt(s) have been made to collect, then my information will be referred to collections and/or legal action will be brought against me and I will be responsible for ANY and ALL reasonable attorney's fees, costs and expenses incurred by the facility/physician/supplier of services.

I agree to "grant" and "convey" a "LIEN" to the facility and its provider(s), if my visits are related to an accident (auto, employment, or other type of accident); to satisfy any outstanding debt obligation(s) owed.

I understand I have the right to revoke authorization(s) at any time; by submitting such request(s) in writing to the facility. I understand that any cancellation of my authorization will be effective when the facility receives my signed request, but it will not apply to information that was used or disclosed prior to that date. **I understand I have the right to receive** a copy of authorization(s).

Signature of Guarantor:_____ Date: ____/____/____

CONSENT FORM

The undersigned consents to any examination (x-ray or otherwise) including, but not limited to, physical, orthopedic and neurological evaluations, visual inspection, palpation, exercise stress test, electromyography (EMG), electrocardiograph (EKG), photography, etc.

The undersigned also consents to observation of therapeutic or other procedures by staff personnel or personnel in training as permitted by the attending practitioner. Treatment procedures that may be used in your treatment may include, but are not limited to, adjusting procedures, joint mobilization, myofascial release, trigger-point therapy, ultra sound, diathermy, electrical therapy, traction, muscle stretching, hydrocollator therapy, cryo-therapy, thermos-therapy nutritional supplementation, rehabilitative exercise, and/or massage.

Chiropractic has only one goal: to eliminate misalignments within the spinal column (vertebral subluxation) which may interfere with nerve function preventing the body from expressing its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. If you desire advice, diagnosis, or treatment for non-Chiropractic issues, we recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE is to attempt to reduce major interference to the expression of the body's innate wisdom.**

Because of modern techniques and equipment, examination and therapeutic procedures carry with them a low risk of complication. Even though problems seldom arise during these procedures, risks must be recognized and considered. Any procedure intended to help, may also do harm. While examination and therapeutic procedures used in this clinic are considered safe, effective, and/or beneficial, understand that occasionally there may be adverse reactions that occur. Although the chances of experiencing any of these complications are small, it is the practice of this office to inform and educate our patients. Complications reported in the literature include, but are not limited to pain, swelling, bruising, discoloration, inflammation, disc injury, sensory changes, bleeding, fracture, fainting, irregular heartbeat, heart attack, spinal cord damage, nausea, burns, soft tissue injury, stroke, dizziness, or weakness. All patients respond differently to treatment procedures.

If you do not fully understand the above or have questions about anything mentioned in this document, please do not sign it until these matters have been resolved with further discussion.

I, (the undersigned) have read the above explanation of treatment and diagnostic procedures used in this clinic and have myself decided that it is in my best interest to submit to these procedures.

Printed Name: _____

Patient Signature:_____ Date: _____

Witness: _____