

Date: \_\_\_\_\_

\_\_\_\_\_  
First Name M.I. Last Name

Male  Female

\_\_\_\_\_  
Date of Birth (MM/DD/YY) Social Security # (Required)

\_\_\_\_\_  
Address City, State Zip

\_\_\_\_\_  
Cell Phone Home Phone Email Address

\_\_\_\_\_  
Employer Occupation Phone

\_\_\_\_\_  
Spouse Name Phone

\_\_\_\_\_  
Emergency Contact Phone Relationship

\_\_\_\_\_  
Primary Physician Phone

\_\_\_\_\_  
Chief Complaint

\_\_\_\_\_  
Whom may we thank for referring you today?

<b>CONFIDENTIAL HEALTH INFORMATION</b>	<b>Acknowledgements</b>	
	Please read each statement below and initial your agreement.	
	Initial _____	I acknowledge any quote of insurance payment is NOT a guarantee of payment. I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.
	Initial _____	I have read and reviewed the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.
	Initial _____	I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, or health information to me as an extension of my care in the office.
Initial _____	I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant.	
	<b>To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.</b>	
	_____ Signature of Patient or Parent of patient if a minor	



## Informed Consent To Treat

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Please print clearly

I hereby request and consent to the performance of procedures, including various modes of physiotherapy, chiropractic adjustments, examinations, acupuncture, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by this location and/or other licensed providers and support staff who now or in the future treat me while employed by, working or associated with or as back-up, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with this location provider and/or with other office or clinic personnel the nature and purpose of the procedures.

I understand and I am informed that, as is with all healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all healthcare treatments, there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect this location provider to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

I further understand that treatment is designed to improve health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued.

I further understand that there are treatment options available for my condition, these treatment options include, but limited to self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other options if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Signature of Patient: \_\_\_\_\_

If Patient is a minor, what is relationship to Patient: \_\_\_\_\_

Guardian/Parental Signature: \_\_\_\_\_