Lake Cities Chiropractic Center **WELCOME**

3504 Corinth Pkwy Ste. 110 Corinth, TX 76208 P: 940-497-3147 F: 940-497-3148 E-mail: dr.scott@lakecitieschiropractic.com

Patient Information

Date:_____/_____/_____

Social Sec. # ______________________________

Patient Name ______________________________
Last Name First Name Middle Initial

Address______________________________

City______________________________

State________________ Zip________________

E-mail______________________________

Sex ☐ Male ☐ Female Age________

Birthdate _____/______/______

☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered

Occupation______________________________

Patient Employer/School______________________________

Employer/School Address ______________________________

City______________________________

State________________ Zip________________

Employer/School Phone______________________________

How did you hear about us? ______________________________

Spouse's Name______________________________

Birthdate______________________________

SS#______________________________

Spouses Employer______________________________

Staff Use Only

- Patient Chief Complaint Summary: ______________________________
- SP Symptom Survey Form:______________________________
- Wellness Wheel Total Score: ________ Lowest: ________________
- Toxicity Form - Section I:_____ Section II:_____ Total:_____
- Acidity Form - Section I:_____ Section II:_____ Total:_____
- Posture Exam Notes:______________________________
- Thermography Notes: ______________________________
- X-Rays Taken: ☐ C-SP ☐ T-Sp ☐ L-Sp ☐ ___ Shoulder ☐___ Elbow ☐___ Knee ☐___ Foot
- Diagnosis Codes: ______________________________

Phone Numbers

Home Phone (_____)______________________________

Cell Phone (_____)______________________________

Best time and place to reach you______________________________

In Case of Emergency Contact______________________________

Name______________________________

Relationship______________________________

Home Phone ______________________________

Work Phone______________________________

Accident Information

Is condition due to an accident or injury? ☐ Yes ☐ No

Date of Accident_____/_____/_____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

Who have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Work Comp. ☐ Attorney ☐ Other

Attorney Name (if applicable)______________________________

Claim Adjuster (if applicable) ______________________________

Case Manager (if applicable)______________________________

Case #______________________________

Informed Consent

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between the provider and the patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the ate of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff of Lake Cities Chiropratic Center to perform any and all necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information provided.

Signature______________________________ Date____/____/____ ☐ Adult ☐ Guardian ☐ Spouse ☐ Representative

Consent for X-Ray Examination

I ______________________________ do hereby give my permission to Lake Cities Chiropractic Center and its representatives to take X-RAYS as deemed appropriate by the examining doctor. I also hereby declare that to my knowledge, I am not pregnant.

______________________________ ________________________
Signature Date

Health History

What treatment have you already received for your condition? ☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Chiropractor ☐ Other:
____

Name and address of other doctor(s) who have treated you for your condition?_______________________________________

Date of your last: Physical Exam_______________ Spinal X-Ray_____________ Blood Test_____________ Bone Density____________
MRI, CT-Scan, Bone Scan_____________ Urine Test______________ Posture Exam:____________

Place a mark on Y or N to indicate if you have had any of the following:

AIDS	☐ Y	☐ N	Emphysema	☐ Y	☐ N	Miscarriage	☐ Y	☐ N	Stroke	☐ Y	☐ N
Alcoholism	☐ Y	☐ N	Epilepsy	☐ Y	☐ N	Mononucleosis	☐ Y	☐ N	Suicide Attempt	☐ Y	☐ N
Allergies	☐ Y	☐ N	Fractures	☐ Y	☐ N	Multiple Sclerosis	☐ Y	☐ N	Thyroid Problems	☐ Y	☐ N
Anemia	☐ Y	☐ N	Glaucoma	☐ Y	☐ N	Mumps	☐ Y	☐ N	Tonsillitis	☐ Y	☐ N
Anorexia	☐ Y	☐ N	Goiter	☐ Y	☐ N	Osteoporosis	☐ Y	☐ N	Tuberculosis	☐ Y	☐ N
Appendicitis	☐ Y	☐ N	Gonorrhea	☐ Y	☐ N	Osteopenia	☐ Y	☐ N	Tumors	☐ Y	☐ N
Arthritis	☐ Y	☐ N	Gout	☐ Y	☐ N	Pacemaker	☐ Y	☐ N	Growths	☐ Y	☐ N
Asthma	☐ Y	☐ N	Heart Disease	☐ Y	☐ N	Parkinson's	☐ Y	☐ N	Typhoid	☐ Y	☐ N
Bleeding Disorders	☐ Y	☐ N	Hepatitis	☐ Y	☐ N	Pinched Nerve	☐ Y	☐ N	Ulcers	☐ Y	☐ N
Breast Lump	☐ Y	☐ N	Hernia	☐ Y	☐ N	Pneumonia	☐ Y	☐ N	Vaginal Infections	☐ Y	☐ N
Bronchitis	☐ Y	☐ N	Herniated Disc	☐ Y	☐ N	Polio	☐ Y	☐ N	Whooping Cough	☐ Y	☐ N
Bulimia	☐ Y	☐ N	Herpes	☐ Y	☐ N	Prostate Problem	☐ Y	☐ N	Other ▶		
Cancer	☐ Y	☐ N	High Cholesterol	☐ Y	☐ N	Prosthesis	☐ Y	☐ N			
Cataracts	☐ Y	☐ N	Kidney Disease	☐ Y	☐ N	Psychiatric Care	☐ Y	☐ N			
Drug Dependency	☐ Y	☐ N	Liver Disease	☐ Y	☐ N	Rheumatoid Arthritis	☐ Y	☐ N			
Chicken Pox	☐ Y	☐ N	Measles	☐ Y	☐ N	Rheumatic Fever	☐ Y	☐ N			
Diabetes	☐ Y	☐ N	Migraines	☐ Y	☐ N	Scarlet Fever	☐ Y	☐ N			

Exercise	Work Activity	Habits		Please List Any Significant Injuries	Date
☐ None	☐ Sitting	☐ Smoking		☐ Falls	
☐ Moderate	☐ Standing	☐ Alcohol		☐ Head Injuries	
☐ Daily	☐ Light Labor	☐ Drug Use		☐ Broken Bones	
☐ Heavy	☐ Moderate Labor	☐ Caffeine		☐ Dislocations	
☐ Training	☐ Heavy Labor	☐ High Stress		☐ Sprain/Strains	

Medications	Allergies	Vitamins/Herbs/Minerals	Please list Any Surgeries	Date
1.	1.	1.	1.	
2.	2.	2.	2.	
3.	3.	3.	3.	
4.	4.	4.	4.	

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY

1. What would you like to achieve from seeking care at our office? (eg.. better health, better range of motion, get out of pain…)
____

2. What do you feel is or has been hindered by the condition(s) you are seeking help for? (eg.. golf game, driving, sitting, play with kids)
____

3. What, if any are your previous experiences with chiropractic care? (eg.. good, bad, certain adjustment technique)
____

4. Would you be interested in utilizing Clinical Aromatherapy/Essential Oil Therapy in conjunction with your treatment at our office?

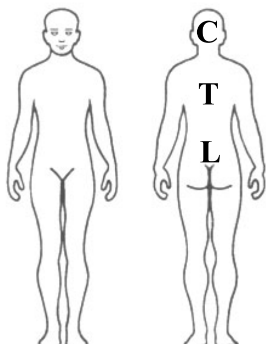
☐ Yes ☐ No Comments:____

5. Do we have permission to communicate with you through e-mail? Typically we may use e-mail for the following: Sending and receiving forms, exercise plans, goal worksheets, information updates, monthly newsletters, clinic specials on products ect…This authorization is effective through 01-01-2015 unless written revocation to this office is received. ______________ Initial Please.

☐ Yes ☐ No E-mail you would like us to use:____

Chief Complaint:______________________________________
____
____
Where did the problem begin? ☐ Home ☐ Work ☐ Play ☐ Travel
Date of Onset:______________________________
Mode of Onset: ☐ Sudden ☐ Gradual Worsening ☐ Chronic
____
Location: ☐ Neck ☐ Mid-Back ☐ Low Back ☐ Pelvis ☐ Other:
____

FRONT **BACK**



Pain: **C** 1 2 3 4 5 6 7 8 9 10 **T** 1 2 3 4 5 6 7 8 9 10 **L** 1 2 3 4 5 6 7 8 9 10

Quality: ☐ Dull ☐ Sharp ☐ Stabbing ☐ Ache ☐ Tingle ☐ Numb ☐ Burn ☐Tight ☐Locked ☐ Soreness ☐ Annoying

Frequency: ☐ Constant ☐ Intermittent ☐ Intensity Fluctuates
Hindered: ☐ ADL ☐ Sports ☐ Kids ☐ Work
Radiate? ☐ R ☐ L ☐ Shoulder ☐ Arm ☐ Hand ☐ Leg ☐ Foot
Has it gotten progressively? ☐ Worse ☐ Better ☐ No Change
Aggravating Factors? ☐ Walking ☐ Sitting ☐ Standing ☐ Sleep
Worse w/ Activity? ☐ Yes ☐ No: ____________________
Reliving Factors? ______________________ ☐ Pt. Denies
Do any positions relieve the pain? ☐ Yes ☐ No ☐ No Change
☐ Sitting ☐ Walking ☐ Lying: ☐ Up ☐ Down ☐ Side____
Position you sleep in? ☐ Face Up ☐ Face Down ☐ Side ____
Is the Condition: ☐ Better ☐ Worse ☐ N/C in the ☐ AM ☐ PM
Has it affected any other systems? ☐ Yes ☐ Pt. Denies
☐ Urinary ☐ Bowel ☐ Cardiac ☐ Respiratory ☐ Vision
Do you get Headaches? ☐ Yes ☐ No **Frequency:** ___ da/wk/mo
Is it worse if you cough or sneeze? ☐ Yes ☐ No **Loc**:________
Is the patient house confined? ☐ Yes ☐ No Duration:________
Have you missed work? ☐ Yes ☐ No Amount:_____________
Date patient returned to normal work? ____/____/____ ☐ N/A

Have you ever had this condition before? ☐ Yes ☐ No
When:__________________ # of prev. episodes?_____________
Duration: ______________________________
Treatment: ☐ Chiro. ☐ MD ☐ DO ☐ PT ☐ Other:___________
Results: ☐ Good ☐ Condition worse ☐ No Change

Have administered any home remedies? ☐ Yes ☐ No
☐ OTC ☐ Ice ☐ Heat ☐ Massage ☐ Analgesic Creams
What:______________________________________
Result: Did it help? ☐ Yes ☐ No ______________________

Diagnosis 1.______________ 2.______________ 3.____________
4.______________ 5.______________ 6.____________

Consulted any other Dr.'s for this condition? ☐ Yes ☐ No
Name:______________________________________
Address:______________________________________
Still under care? ☐ Yes ☐ No | ☐ PCP ☐ Ortho ☐ Neuro
Prescription(s):________________________________
Remarks:________________________________
____
Was surgery recommended? ☐ Yes ☐ No :________________
Result of Treatment? ☐ Good ☐ Condition worse ☐ No Change

Have you had previous chiropractic care? ☐ Yes ☐ No
Location:______________________________________
When: ___________________Last Adjustment ____/____/____
Why: ______________________________________
X-rays on file: ☐ Yes ☐ No Loc: ☐ C ☐ T ☐ L ☐ P ☐ E
Result of Treatment: ☐ Good ☐ Condition worse ☐ No Change

Do you have any secondary complaints? ____________________
____
____

Have you Previously worn custom orthotics? ☐ Yes ☐ No
Have you Previously undergone rehabilitation? ☐ Yes ☐ No
Have you ever undergone spinal decompression? ☐ Yes ☐ No
Have you ever had your spine scanned for neurological disturbances? ☐ Yes ☐ No

Do you normally take vitamins or supplements? ☐ Yes ☐ No
Are you currently dieting or watching your weight? ☐ Yes ☐ No
Do you drink adequate water on a daily basis? ☐ Yes ☐ No
Do you currently have a gym membership? ☐ Yes ☐ No
Do you eat out more frequently than at home? ☐ Yes ☐ No
Do you have meals on a regular basis? ☐ Yes ☐ No
Would you generally say that you are happy? ☐ Yes ☐ No
Do you drive long distances in traffic frequently? ☐ Yes ☐ No
Are you conscious about your posture? ☐ Yes ☐ No

Our patients choose our office because they want a natural approach to better health. On your first visit you'll meet the doctor to discuss your current health situation and to see if you're a good candidate for chiropractic care. If we think we can help, we'll conduct a thorough examination. This helps us identify the likely cause(s) of your problem. We'll tell you what we found, what we can do to help, how long it may take and how much it will cost. Our office enjoys high levels of patient satisfaction because we explain everything in advance. Find out for yourself!

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Lake Cities Chiropractic Center, P.C. or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office.

You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

Your may request a restriction on the use or disclosure of your Protected Health Information.

This office may or may not agree to restrict the use or disclosure of your Protected Health Information.

If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change privacy practice

This office reserves the right to modify the privacy practices outlined in the Notice.

Signature

I have reviewed this consent form and give my permission to this office to use and disclose my health information in accordance with it.

____

Name of Patient (print)

____

Signature of Patient **Date**

____

Signature of Patient Representative **Date**

____

Relationship of Patient Representative to Patient

____

Office Representative **Date**

____

Others we may release your PHI to

Wellness Questionnaire

On a scale of 0 (poor) to 10 (excellent) mark your current health levels in these 7 essential areas.

1. **Mental Health**
   a. Are you open to new ideas? Do you seek out new ideas and experiences to learn new skills what is the quality of the information and information that you allow into your mind?
   b. Rate Yourself accordingly: ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

2. **Physical Health**
   a. What is your physical condition? Are you receiving good nutrition, drinking plenty of water, getting regular exercise, and enjoying the proper weight for your height?
   b. Rate Yourself accordingly: ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

3. **Financial Health**
   a. Are you living within your means? Is your debt within manageable limits? Do you make charitable contributions and save for the future? Are you properly insured?
   b. Rate Yourself accordingly: ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

4. **Family Health**
   a. Are you in a loving relationship with shared values? Do you give your family time and attention? Do you have a close connection with children, parents, and relatives?
   b. Rate Yourself accordingly: ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

5. **Social Health**
   a. How well do interact with others? Are you able to maintain long-term friendships? Are you comfortable in new social situations and the company of others.
   b. Rate Yourself accordingly: ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

6. **Career Health**
   a. Do you like what you do for a living? Does your career reflect and advance your deepest values? Is your work meaningful and suited to your skills and interest?
   b. Rate Yourself accordingly: ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

7. **Spiritual Health**
   a. How connected do you feel to the higher power in your life? Do you enjoy a sense of purpose and peace? Do you regularly study, meditate, pray or worship?
   b. Rate Yourself accordingly: ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

Your health affects everything you do and everyone you know. We use this confidential worksheet to record a “snapshot” of your estimated overall health so we can track your progress.

Toxicity Questionnaire

SECTION I: SYMPTOMS - Rate each of the following based upon your health profile for the past 90 (Ninety) days.

Use This Key – Circle the corresponding number below for Section I, groups 1-15			
0	Rarely or never experience the symptom	**3**	Frequently experience the symptom, the effect is not severe.
1	Occasionally experience the symptom, the effect is not severe.	**4**	Frequently experience the symptom, the effect IS severe.
2	Occasionally experience the symptom, the effect IS severe.		

1. DIGESTIVE

a. Nausea and/or vomiting	0	1	2	3	4
b. Diarrhea	0	1	2	3	4
c. Constipation	0	1	2	3	4
d. Bloated feeling	0	1	2	3	4
e. Belching and/or passing gas	0	1	2	3	4
f. Heartburn	0	1	2	3	4

Total:________

2. EARS

a. Itchy ears	0	1	2	3	4
b. Earaches, ear infections	0	1	2	3	4
c. Drainage from ear	0	1	2	3	4
d. Ringing in ears, hearing loss	0	1	2	3	4

Total:________

3. EMOTIONS

a. Mood swings	0	1	2	3	4
b. Anxiety, fear, nervousness	0	1	2	3	4
c. Anger, irritability	0	1	2	3	4
d. Depression	0	1	2	3	4
e. Sense of despair	0	1	2	3	4
f. Apathy / Lethargy	0	1	2	3	4

Total:________

4. ENERGY / ACTIVITY

a. Fatigue / Sluggishness	0	1	2	3	4
b. Hyperactivity	0	1	2	3	4
c. Restlessness	0	1	2	3	4
d. Insomnia	0	1	2	3	4
e. Startled awake at night	0	1	2	3	4

Total:________

5. EYES

a. Watery, itchy eyes	0	1	2	3	4
b. Swollen, reddened, sticky lids	0	1	2	3	4
c. Dark circles under eyes	0	1	2	3	4
d. Blurred / tunnel vision	0	1	2	3	4

Total:________

6. HEAD

a. Headache	0	1	2	3	4
b. Faintness	0	1	2	3	4
c. Dizziness	0	1	2	3	4
d. Pressure	0	1	2	3	4

Total:________

7. LUNGS

a. Chest congestion	0	1	2	3	4
b. Asthma, Bronchitis	0	1	2	3	4
c. Shortness of breath	0	1	2	3	4
d. Difficulty breathing	0	1	2	3	4

Total:________

8. MIND

a. Poor memory	0	1	2	3	4
b. Confusion	0	1	2	3	4
c. Poor concentration	0	1	2	3	4
d. Poor coordination	0	1	2	3	4
e. Difficulty making decisions	0	1	2	3	4
f. Stuttering, stammering	0	1	2	3	4
g. Slurred speech	0	1	2	3	4
h. Learning disabilities	0	1	2	3	4

Total:________

9. MOUTH / THROAT

a. Chronic coughing	0	1	2	3	4
b. Gagging, need to clear throat	0	1	2	3	4
c. Swollen or discolored tongue, gums or lips.	0	1	2	3	4
d. Canker sores	0	1	2	3	4

Total:________

10. NOSE

a. Stuffy nose	0	1	2	3	4
b. Sinus problems	0	1	2	3	4
c. Hay fever	0	1	2	3	4
d. Sneezing attacks	0	1	2	3	4
e. Excessive mucous	0	1	2	3	4

Total:________

11. SKIN

a. Acne	0	1	2	3	4
b. Hives, rashes, dry skin	0	1	2	3	4
c. Hair loss	0	1	2	3	4
d. Flushing	0	1	2	3	4
e. Excessive sweating	0	1	2	3	4

Total:________

12. HEART

a. Skipped heartbeats	0	1	2	3	4
b. Rapid Heartbeats	0	1	2	3	4
c. Chest pain	0	1	2	3	4

Total:________

13. JOINTS / MUSCLES

a. Pain or aches in joints	0	1	2	3	4
b. Rheumatoid arthritis	0	1	2	3	4
c. Osteoarthritis	0	1	2	3	4
d. Stiffness, limited movement	0	1	2	3	4
e. Pain, aches in muscles	0	1	2	3	4
f. Recurrent back aches	0	1	2	3	4
g. Feeling of weakness or tired	0	1	2	3	4

Total:________

14. WEIGHT

a. Binge eating/drinking	0	1	2	3	4
b. Craving certain foods	0	1	2	3	4
c. Excessive weight	0	1	2	3	4
d. Compulsive eating	0	1	2	3	4
e. Water retention	0	1	2	3	4
f. Underweight	0	1	2	3	4

Total:________

15. OTHER

a. Frequent illness	0	1	2	3	4
b. Frequent or urgent urination	0	1	2	3	4
c. Leaky bladder	0	1	2	3	4
d. Genital itch, discharge	0	1	2	3	4

Total:________

SECTION I TOTAL:_____________

SECTION II RISK OF EXPOSURE: Answer the following situations based upon your environmental profile for the past 120 days.

0 Never	**1** Rarely	**2** Monthly	**3** Weekly	**4** Daily					
16. Circle the corresponding number for questions 16a-16f below									
a. How often are strong chemicals used in your home? (disinfectants, bleaches, oven/drain cleaners, furniture polish, floor wax etc.)					0	1	2	3	4
b. How often are pesticides used in your home?					0	1	2	3	4
c. How often do you have your home treated for insects?					0	1	2	3	4
d. How often are you exposed to dust, overstuffed furniture, tobacco smoke, mothballs , incense, varnish in your home or office?					0	1	2	3	4
e. How often are you exposed to nail polish, perfume, hair spray, and other cosmetics?					0	1	2	3	4
f. How often are you exposed to diesel fumes, exhaust fumes, or gasoline fumes?					0	1	2	3	4

0 No	**1** Mild Change	**2** Moderate Change	**3** Drastic Change				
17. Circle the corresponding number for questions 17a-1b below							
a. Have you noticed any negative change in your health since you moved into your home or apartment?				0	1	2	3
b. Have you noticed any negative change in your health since you started your latest job?				0	1	2	3

18. Answer yes or no and circle the corresponding number for questions 18a-18d below.	**NO**	**YES**
a. Do you have a water purification system in your home?	2	0
b. Do you have any indoor pets?	0	2
c. Do you have an air purification system in your home?	2	0
d. Are you a dentist, painter, farm worker, or construction worker?	0	2

Total Score > 40 or greater than 6 points per section, Clinical Purification is suggested. **I II III** **SECTION II TOTAL:__________**

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me.
I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

____________________	____________________	__________
Printed Name	**Signature**	**Date**

WITNESS:

____________________	____________________	__________
Printed Name	**Signature**	**Date**

OFFICE POLICY REGARDING INSURANCE ASSIGNMENT

Please read the following office policy regarding assignments:

1. At the beginning of your treatment our office will make every attempt to verify your policy benefits, however, this office DOES NOT guarantee your insurance policy or payments.

2. Your insurance will be filed as a courtesy to you. We file insurance claims on a daily basis.

2. You may be charged for a missed appointment unless you contact our office within 1 hour of your appointment..

3. We will be charging interest of 5% on unpaid balances should they become delinquent after 30 days.

4. You will be responsible for your deductible and co-payment. If your insurance company does not pay something that was anticipated, you will be responsible for the amount as soon as we/you are aware of the denial.

5. Your insurance should pay within 45 days from the date in which it was filed.

6. By taking your insurance on assignment, our office agrees to wait for a portion of your bill for an estimated amount of time. In the event that your insurance company does not pay on a timely basis, you may be asked to contact your insurance carrier.

7. If your insurance company mails a check directly to you for our services, you must bring the misdirected check to our office within 48 hours.

8. Any overpayments made by your insurance company which credits your account will be refunded to them. However, any overpayments or errors in amounts paid which does not credit your account will be your responsibility.

9. If you discontinue care without the doctor's authorization, the balance on your account is due and payable immediately, even if your insurance has been filed. (If your insurance does pay, after your account has been paid, refunds will be sent to you.)

I have read and understand the policy regarding insurance assignments. I realize that I am responsible for all charges incurred by me at this office.

______________________________________ ________________________
Signature Date

______________________________________ ________________________
Witness Date