WELCOME TO HENRY CHIROPRACTIC

Grimsley,Chiropractic Services, P.C
22780 Three Notch Road, Lexington Park, MD 20653
Phone: 301-737-0662 Fax: 301-737-0675

Full Name:	Date:	Circle: M or F
How did you hear about us?	Date of Birth:	Age:
Address:		
City, State, Zip code:		
Home phone:	Cell:	Work:
Employer:	Occupation:	
Name of Spouse:	Email:	
Emergency Contact:	Relationship:	Phone:

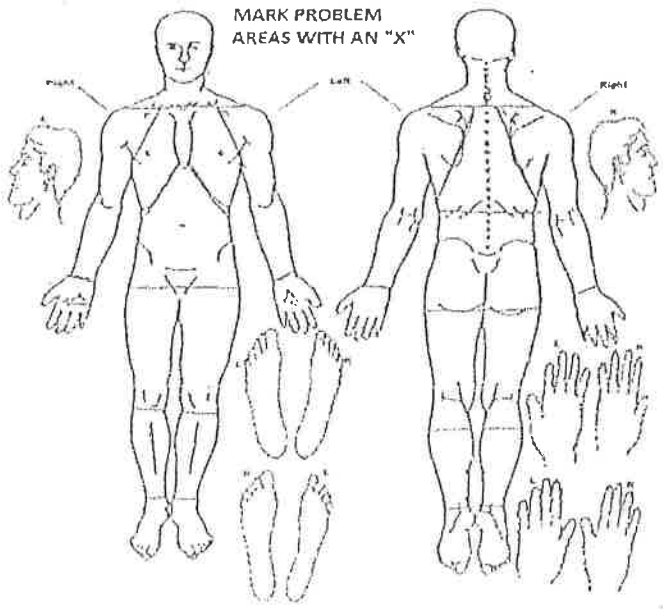
Health Insurance Information

Primary Insurance	Secondary Insurance
Insurance Carrier:	Insurance Carrier:
ID#:	ID#:
Group#:	Group#:
Name of Insured:	Name of Insured:
Relationship: ☐Self ☐Spouse ☐Child ☐Other	Relationship:☐Self ☐Spouse ☐Child ☐Other
Insured's DOB:	Insured's DOB:
Insured Employer:	Insured Employer:

I certify that I, and/or my dependent(s) have insurance coverage with & assign directly to GCS, P.C. all insurance benefits, if any, otherwise, payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. GCS, P.C. may use my health care information & may disclose such information to the above named insurance companies & their agents for the purpose of obtaining payment for services & insurance benefits or the benefits payable for related services. A photocopy of the Assignment shall be considered as effective & valid as the original.

Signature_____ Printed Name:_____ Date:_____

YOUR CONDITION



Reason for visit:

Onset Date:

Condition is getting: ☐Worse ☐Better ☐Same

Rate your pain (1=least, 10=severe):

Frequency of the pain:

Pain interferes with:
☐Work ☐Daily Routine ☐Recreation

Pain to perform:
☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying

Type of Pain: ☐Aching ☐Burning ☐Cramps ☐Dull ☐Numbness ☐Sharp ☐Shooting ☐Stabbing ☐Stiff ☐Swelling ☐Throbbing ☐Tingling ☐Other

Health History

What Treatment have you already received for your condition?

☐ Medications ☐Physical Therapy ☐Surgery ☐ Chiropractic ☐None ☐Other_____

Name/Facility of Doctor(s) who have treated you for this condition:

_____

Please fill in the dates of your last:

Physical Exam _____
Spinal X-ray _____
Blood Test _____
Chest X-ray _____
Spinal Exam _____
CT Scan _____
MRI _____
Bone Scan _____

List Location of Lab Work or Radiology Services: _____

Exercise	Work Activity	Habits	PLEASE LIST ALL:
☐None	☐Sitting	☐Smoking	**Medications:**
☐Moderate	☐Standing	☐Alcohol	**Allergies:**
☐Daily	☐Light	☐Caffeine	**Surgeries, Falls, Broken Bones:**
☐Heavy	☐Heavy	☐Stress	

Check if you have had any of the following:

☐AIDS/HIV
☐Alcoholism
☐Allergy Shots
☐Anemia
☐Anorexia
☐Appendicitis
☐Arthritis
☐Asthma
☐Bleeding disorder
☐Bladder Disease
☐Bone Disease
☐Bowel Disorder
☐Bronchitis
☐Bulimia
☐Cancer
☐Cataracts
☐Chemical Dependencies
☐Chicken Pox
☐Diabetes
☐Emphysema
☐Epilepsy
☐Eye Disorder
☐Fractures
☐Gall Bladder Disease
☐Glaucoma
☐Gout
☐Headaches
☐Heart Disease
☐Herniated Disc
☐Hernia
☐High Cholesterol
☐Hypertension
☐Kidney Disease
☐Liver Disease
☐Low Back Pain
☐Lung Disease
☐Measles
☐Migraines
☐Mononucleosis
☐Multiple Sclerosis
☐Mumps
☐Nerve Disorder
☐Osteoporosis
☐Pacemaker
☐Parkinson's Disease
☐Pneumonia
☐Polio
☐Rheumatoid Arthritis
☐Scarlet Fever
☐Spinal Disorders
☐Stomach Disorders
☐Stroke
☐Thyroid Problems
☐Tonsillitis
☐Tuberculosis
☐Tumors/Growths
☐Typhoid Fever
☐Ulcers
☐Whooping Cough
☐Other_____

NDI

Patient Name:_____ Date:_____

Please read instructions:

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but just mark the box which most closely describes your problem.

SECTION 1- PAIN INTENSITY

[ ] I have no pain at the moment.
[ ] The pain is very mild at the moment.
[ ] The pain is moderate.
[ ] The pain is fairly severe at the moment.
[ ] The pain is very severe at the moment.
[ ] The pain is the worst imaginable at the moment.

SECTION 2 – PERSONAL CARE

(washing, dressing, etc...)

[ ] I can look after myself normally with out causing extra pain.
[ ] I can look after myself normally but it causes extra pain.
[ ] It is painful to look after myself & I am slow & careful.
[ ] I need some help but manage most of my personal care.
[ ] I need help every day in most aspects of self care.
[ ] I do not get dressed. I wash with difficulty & stay in bed.

SECTION 3- LIFTING

[ ] I can lift heavy weights without extra pain.
[ ] I can lift heavy weights but it gives extra pain.
[ ] Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned. Ex. On table.
[ ] Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
[ ] I can lift very light weights.
[ ] I cannot lift or carry anything at all.

SECTION 4- READING

[ ] I can read as much as I want with no pain in my neck.
[ ] I can read as much as I want to with slight pain in my neck.
[ ] I can read as much as I want with moderate pain in my neck.
[ ] I can't read as much as I want because of moderate pain in my neck.
[ ] I can hardly read at all because of severe pain in my neck.
[ ] I cannot read at all.

SECTION 5-HEADACHES

[ ] I have no headaches at all.
[ ] I have slight headaches which come infrequently.
[ ] I have moderate headaches which come infrequently.
[ ] I have moderate headaches which come frequently.
[ ] I have severe headaches which come frequently.
[ ] I have headaches almost all the time.

SECTION 6- CONCENTRATION

[ ] I can concentrate fully when I want to with no difficulty.
[ ] I can concentrate fully when I want to with slight difficulty.
[ ] I have a fair degree of difficulty concentrating when I want to.
[ ] I have a lot of difficulty concentrating when I want to.
[ ] I have a great deal of difficulty concentrating when I want to.
[ ] I cannot concentrate at all.

SECTION 7- WORK

[ ] I can do as much work as I want to.
[ ] I can only do my usual work, but no more.
[ ] I can do most of my usual work, but no more.
[ ] I cannot do my usual work.
[ ] I can hardly do any work at all.
[ ] I can't do any work at all.

SECTION 8- DRIVING

[ ] I can drive my car without any neck pain.
[ ] I can drive my car as long as I want with slight pain in neck.
[ ] I can drive my car as long as I want with moderate pain in my neck.
[ ] I can't drive my car as long as I want because of moderate pain in my neck.
[ ] I can hardly drive at all because of severe pain in my neck.

[ ] I can't drive my car at all.

SECTION 9- SLEEPING

[ ] I have no trouble sleeping.
[ ] My sleep is slightly disturbed (less than 1hr. sleepless)
[ ] My sleep is mildly disturbed (1-2 hrs. sleepless)
[ ] My sleep is moderately disturbed (2-3 hrs. sleepless)
[ ] My sleep is greatly disturbed (3-5 hrs. sleepless)
[ ] My sleep is completely disturbed (5-7 hrs. sleepless)

SECTION 10- RECREATION

[ ] I am able to engage in all my recreation activities with no neck Pain at all.
[ ] I am able to engage in all my recreation activities, with some Pain in my neck.
[ ] I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
[ ] I am able to engage in a few of my usual recreation activities because of pain in my neck.
[ ] I can hardly do any recreation activities because of pain in my neck.
[ ] I can't do any recreation activities at all.

Pain Scale:

Rate the severity of your pain by circling one number on the following scale

No Pain | 0 1 2 3 4 5 6 7 8 9 10 | Excruciating Pain

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ Date of Birth: _____

Phone: H) _____ Phone: W) _____

Address: _____ City/State/Zip: _____

Please Note: Copy Fee May Be Charged For Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: _____ **Facility Phone:** _____

Facility Address: _____ Facility Fax: _____

City, ST, Zip: _____

Dates and Type of information to disclose:

☐ 2 years prior from last date seen
☐ Dates Other: _____
☐ Specific Information Requested:

_____

The purpose of disclosure is:

☐ Change of Insurance or Physician
☐ Continuation of Care (e.g., VA Med Ctr)
☐ Referral
☐ Other _____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To: _____ **HENRY CHIROPRACTIC & WELNESS CENTER** _____

Address: _____ **22780 THREE NOTCH ROAD** _____

City, State, Zip: **LEXINGTON PARK, MD 20650**

☐ **Please mail records.**

Fax: **301-737-0675** Phone: **301-737-0662**

☐ **Please fax records.**

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____.**
If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X _____ _____

Signature of Patient / Parent / Guardian or Authorized Representative (Guardian or Authorized Representative must attach documentation of such status.) Date

_____ _____

Printed name of Authorized Representative Relationship / Capacity to patient

_____

Address and telephone number of authorized representative

Low Back Pain & Disability Questionnaire (Revised Oswestry)

Patient Name: _____ Date: _____

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but just mark the box which most closely describes your problem.

SECTION 1: PAIN INTENSITY

	The pain comes & goes & is mild
	The pain is mild & does not vary much
	The pain comes & goes & is moderate
	The pain comes & goes & is very severe
	The pain is severe & does not vary much

SECTION 2: PERSONAL CARE

	I would not have to change any way of washing & dressing to avoid pain
	I do not normally change my way of washing or dressing even though it causes some pain
	Washing & dressing increases the pain but I manage not to change my way of doing it
	Washing & dressing increases the pain & I find it necessary to change my way of doing it
	Because of the pain I am able to do some washing & dressing without help
	Because of the pain I am unable to do any washing and dressing without help

SECTION 3: LIFTING

	I can lift heavy weights without extra pain
	I can lift heavy weights but it causes extra pain
	Pain prevents me from lifting heavy weights off the floor
	Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned
	Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
	I can only lift very light weights at the most

SECTION 4: WALKING

	I have no pain on walking
	I have some pain on walking but it does not increase with distance
	I cannot walk more than 1 mile without increasing pain
	I cannot walk more than ½ mile without increasing pain
	I cannot walk more than ¼ mile without increasing pain
	I cannot walk at all without increasing pain

SECTION 5: SITTING

	I can sit in any chair as long as I like
	I can only sit in my favorite chair as long as I like
	Pain prevents me from sitting more than 1 hour
	Pain prevents me from sitting more than ½ hour
	Pain prevents me from sitting more than 10 minutes
	I avoid sitting because it increases pain right away

SECTION 6: STANDING

	I can stand as long as I want without pain
	I have some pain with standing but it doesn't increase with time
	I can't stand for longer than 1 hour without increasing pain
	I can't stand for longer than ½ hour without increasing pain
	I can't stand for longer than 10 minutes without increasing pain
	I avoid standing because it increases the pain right away

SECTION 7: SLEEPING

	I have no pain in bed
	I have pain in bed but it doesn't prevent me from sleeping well
	Because of pain my normal night's sleep is reduced by less than ¼
	Because of pain my normal night's sleep is reduced by less than ½
	Because of pain my normal night's sleep is reduced by less than ¾

SECTION 8: SOCIAL LIFE

	My social life is normal & give me no pain
	My social life is normal but increases the degree of pain
	Pain has no significant effect on my social life apart from limiting my more energetic interests (i.e. dancing, etc.)
	Pain has restricted my social life and I do not go out very much
	Pain has restricted my social life to my home
	I have hardly any social life because of the pain

SECTION 9: TRAVELING

	I have no pain when traveling
	I get some pain when traveling but none of my normal forms of traveling
	I get extra pain when traveling but it does not compel me to seek alternative forms of travel
	I get extra pain when traveling which compels me to seek alternative forms of travel
	Pain restricts all forms of travel
	Pain prevents all forms of travel except that done lying down

SECTION 10: CHANGING DEGREE OF PAIN

	My pain is rapidly getting better
	My pain fluctuates but overall is definitely getting better
	My pain seems to be getting better but improvement is slow
	My pain is neither getting better nor worse
	My pain is gradually worsening
	My pain is rapidly worsening

PAIN SCALE: Rate the severity of your pain by circling a number on the scale below:

1 No Pain 5 Moderate Pain 10 Excruciating Pain

At Worst	1	2	3	4	5	6	7	8	9	10
At Average	1	2	3	4	5	6	7	8	9	10
At Best	1	2	3	4	5	6	7	8	9	10

Notice of Privacy Practices
Effective Date: April 14, 2003

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

Understanding Your Health Record:

A record is made each time you visit a hospital, physician, or other health care provider. Your symptoms, examination and test results, diagnosis, treatment, and a plan for future care are recorded. This information is most often referred to as your "health or medical record", and serves as a basis for planning our care and treatment. It also serves as a means of communication among any and all other health professionals who may contribute to your care. Understanding what information is retained in your record and how that information may be used will help you to ensure accuracy and enable you to relate to who, what, when, where, and why others may be allowed to access your health information. This effort is being made to assist you in making informed decisions before authorizing the disclosure of your medical information to others. Use or disclosure of your health information will follow the more stringent of State or Federal laws.

Understanding Your Health Information Rights:

Your health record is the physical property of the health care practitioner or facility that compiled it but the content is about you, and therefore belongs to you. You have the right to request restrictions on certain uses and disclosures of your information, and to request amendments be made to your health record. Your rights include being able to review or obtain a paper copy of your health information, and to be given an account of all disclosures. You may also request communications of your health record be made by alternative means or to alternative locations. Other than activity that has already occurred, you may revoke any further authorizations to use or disclose your health information.

Our Responsibilities:

This office is required to maintain the privacy of your health information and to provide you with notice of our legal commitment and privacy practices with respect to the information we collect and maintain about you. This office is required to abide by the terms of this notice and to notify you if we are unable to grant your requested restrictions or reasonable desires to communicate your health information by alternative means or to alternative locations.

This office reserves the right to changes it practices and effect new provisions that enhance the privacy standards of all patient medical information. In the event that changes are made, this office will notify you at the current address provided on your medical file. If applicable, this office will post changes on our website that provides information about our customer service and/or benefits. Other than the reason described in this notice, this office agrees not to use or disclose your health information without your authorization.

To receive additional information or to report a problem:

For further explanation of this notice you may contact our Privacy Officer at (301) 737-0662. If you believe your privacy rights have been violated, you have the right to file a complaint with this office by contacting the individual above, or by contacting the Secretary of Health and Human Services, with no fear of retaliation by this office.

Your Health Information Will Be Used For Treatment, Payment, and Health Care Operations:

Treatment---Information obtained by your health practitioner in this office will be recorded in your medical record and used to determine the course of treatment that should work best for you. This consists of your physician recording his/her own expectations and those others involved in providing your care such as his/her physician assistant, nurse, or medical assistant. The sharing of your health information may progress to others involved in your care, such as specialty physicians or lab technicians.

Payment---Your health care information will be used in order to receive payment for services rendered by this office. A bill may be sent to you or a third-party payer with accompanying documentation that identifies you, your diagnosis, procedures performed, and supplies used.

Health Care Operations---The medical staff in this office will use your health information to assess the care provided and the outcome of your care compare to others like it. Your information may be reviewed for risk management or quality improvement purposes in our efforts to continually improve the quality and effectiveness of the care and services we provide.

(continued over)

Business Associates---Some or all of your health information may be subject to disclosure through contracts for services to assist this office in providing health care. For example, it may be necessary to obtain specialized assistance to process certain laboratory tests or radiology images. To protect our health information, we require these Business Associates to follow the same standards held by this office through terms detailed in a written agreement.

Notification---Your health care record may be used to notify or assist family members, personal representatives, or other persons responsible for your care to enhance your well-being or whereabouts.

Communications with Family---Using best judgment, a family member, or a close personal friend, identified by you, may be given information relevant to your care and/or recovery.

Upon Your Death--- Your health information may be disclosed consistent with laws governing estate and post-mortem personal matters. Generally, your health information may be disclosed to your personal representative as designated by you and certified by the State and to Funeral Directors with laws governing mortician services.

Organ Procurement Organization---Your health information may be disclosed consistent governing entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation or transplant.

Marketing--This office reserves the right to contact you with information about treatment alternatives and other health related benefits that may be appropriate to you.

Appointment Reminders---This office reserves the right to contact you with appointment reminders through an automated system, by our staff, or via U.S. Postal Service.

Phone Contact---This office reserves the right to contact you via the telephone for such things as test result notification. We may leave a generic message on your answering machine, or with the person answering the phone concerning the nature of the call along with a request that you call us for more specific details.

Research---Your information will be disclosed to researchers upon institutional Review Board approval and upon the assurance that established protocol to ensure the privacy of your health information has been obtained.

Food and Drug Administration (FDA)--- This office is required by law to disclose health information to the FDA related to any adverse effects of food, supplements, products, and product defects for surveillance to enable products recalls, repairs, or replacements.

Workers Compensation---This office will release information to the extent authorized by law in matters of Workers' Compensation.

Public Health---This office is required by law to disclose health information to public health and/or legal authorities charged with tracking reports or birth and morbidity. This office is further required by law to report communicable disease, injury, or disability.

Correction Facilities---This office will release medical information on incarcerated individuals to Correctional Agents or Institutions for the necessary welfare of the individual or for the health and safety of other individuals. The rights outlined in this Notice of Privacy Practices will not be extended to incarcerated individuals.

Law Enforcement--- (1) Your health information will be disclosed for law enforcement purposes as required under State Law or in response to a valid subpoena. (2) Provisions of Federal Law permit the disclosure of your health information to appropriate health oversight agencies, public health authorities, or attorneys in the event that a staff member or business associate of this office believes in good faith that there has been unlawful conduct or violations of professional or clinical standards that may endanger one or more parties, workers, or the general public.

NOTICE OF PRIVACY PRACTICES AVAILABILITY: The terms described in this notice will be posed where registration occurs. All individuals receiving care will be given a hard copy

Patient's Comments:

_____

_____

_____ _____

Signature of Patient or Legal Representative Date

_____ (Description of Legal Representative's Attorney)

CONSENT TO CHIROPRACTIC EXAMINATION AND CARE

I hereby authorize Grimsley Chiropractic Services and its licensed doctors and assistants, based on my complaints and the history I have provided, to undertake an examination and provide an evaluation and treatment plan which may include chiropractic adjustments and other tests and procedures considered therapeutically appropriate. I also wish to rely on Grimsley Chiropractic doctors to make those decisions about my care, based on the facts then known that they believe are in my best interest.

The nature and purpose of the chiropractic examination and evaluation, the chiropractic adjustments and the other procedures that may be recommended during the course of my care have been explained and described to my satisfaction.

By signing below I acknowledge my consent to be examined:

_____
Patient's Printed Name

_____ _____
Patient's Signature Date

The specifics of the doctor's recommendation will be further explained during a Report of Findings following your examination and any subsequent examinations and significant changes in your diagnosis or treatment plan.

Based on current findings, Grimsley Chiropractic doctors have discussed my diagnosis and treatment plan, the benefits and expected improvement with the proposed treatment and the reasonable alternatives to the proposed treatment. They have also explained the cost of my proposed care (or provided me with a current fee schedule) and to the extent practicable the costs of reasonable alternatives to the proposed treatment.

To aid the understanding of my condition and the reasons for the proposed course of care, Grimsley Chiropractic Services has provided me with the information and Grimsley Chiropractic doctors have answered my questions regarding the planned treatments and course of care that I will receive. The doctors of Grimsley Chiropractic Services have also explained that my diagnosis and treatments may change during the course of care and that they will advise me of material changes in my diagnosis and treatment options and answer any additional questions that I may have at any time.

I have been advised that although the incidence of complications associated with chiropractic services is very low, anyone undergoing adjusting or manipulative procedures should know of rare possible hazards and complications which may be encountered or result during the course of care. These include, but are not limited to, fractures, disk injuries, dislocations, sprains, and those which relate to physical aberrations unknown or reasonably undetectable by the doctor.

I understand and accept that:

1. I have the right to withdraw from or discontinue treatment at any time and that the Practice doctors will advise me of any material risks in this regard.
2. That neither the practice of chiropractic nor the medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor during the course of my care.
3. That it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications or an undesirable result does not necessarily indicate an error in judgment or treatment.
4. The Practice does not guarantee as to results with respect any course of care or treatment.
5. My care and treatment will not be observed or recorded for any non-therapeutic purpose without my consent.

I have read this Consent (or have had it read to me) and have also had an opportunity to ask questions about the Consent and understand to my satisfaction the care and treatment I may receive. My signature below acknowledges my consent to the examination, evaluation and proposed course of care and treatments by the Practice.

_____
Patient's Printed Name

_____ _____
Patient's Signature Date

Doctor's Notes:

_____ _____
Signature of Doctor Date

AUTHORIZATION TO PAY CHIROPRACTOR

I hereby authorize the _____ Insurance Company to pay by check made out and mailed directly to:

Henry Chiropractic of St. Mary's
22780 Three Notch Road
Lexington Park, MD 20653

the medical and surgical expense benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for Professional Services rendered. This payment will not exceed my indebtedness to the above mentioned assignee, and I agree to pay, in a current manner, any balance of said Professional Service charges over and above this insurance payment.

If my current policy prohibits direct payment to doctor, then I hereby authorize you to make the check to me and mail it as follows:

Henry Chiropractic of St. Mary's
22780 Three Notch Road
Lexington Park, MD 20653

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Date _____

_____ (Signature of Policyholder)

_____ (Witness)

Missed Appointments

Effective November 1st, 2016, we will allow 2 missed appointments per year before charging $40.00 to your account. In other words, you get 2 "free" no show appointments per calendar year. The appointment will not be charged if you call to cancel or reschedule at least 4 hours prior to the appointment time or left a message on our voicemail.

Thank you for your consideration to our other patients who can fill in during these missed slots.

*Print Name:*_____

*Signature:*_____ *Date:*_____