**Cannon Chiropractic Case History/Patient Information**

Date:\_\_\_\_/\_\_\_\_/\_\_\_\_ Doctor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Social Security #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age:\_\_\_\_\_\_\_\_Birth Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Race:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital: M S W D

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer’s Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_

How many children?\_\_\_\_\_\_\_ Names and Ages of Children:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relation:\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How were you referred to our office?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Medical Doctor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at the office? Yes ( ) No ( )

Please check any and all insurance coverage that may be applicable in this case:

( ) Major Medical ( ) Worker’s Compensation ( ) Medicaid ( ) Medicare ( ) Auto Accident

( ) Medical Savings & Flex Plan ( ) Other

Name of Primary Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Secondary Insurance Company (if any):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow Cannon Chiropractic, PLLC to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing the consent. The following person(s) have my permission to receive my personal health information:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Guardian’s Signature Authorizing Care:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Video:\_\_\_ Scan:\_\_\_ Tour:\_\_\_ Exam:\_\_\_ XRAY: C T L Therapy:\_\_\_\_\_\_\_\_ Checked by Employee:\_\_\_\_\_

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**History of Present and Past Illness:**

Chief Complaint: Purpose of this appointment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date symptoms appeared or accident happened:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this due to: ( ) Auto ( ) Work ( ) Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had the same or a similar condition? Yes ( ) No ( ) If yes, when and describe:\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Days lost from work:\_\_\_\_\_\_\_\_\_\_\_ Date of last physical examination:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a history of stroke or hypertension? Yes ( ) No ( )

Have you had any major illnesses, injuries, falls, auto accidents, or surgeries? Women, please include information about childbirth (include date):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been treated for any health condition by a physician in the last year? Yes ( ) No ( )

If yes, describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What medications or drugs are you taking?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to any medications? Yes ( ) No ( ) If yes, describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have allergies of any kind? Yes ( ) No ( ) If yes, describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any Congenital Conditions? Yes ( ) No ( ) If yes, describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Women: Are you pregnant? Yes ( ) No ( ) If yes, how many weeks?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions now or **P** if you have had any of these conditions previously.

Headaches\_\_\_\_ Nervousness\_\_\_\_ Ears Ring\_\_\_\_ Fever\_\_\_\_

Back Pain\_\_\_\_ Shoulder/Arm Pain\_\_\_\_ Neck Pain\_\_\_\_ Irritability\_\_\_\_

Dizziness\_\_\_\_ Difficulty Urinating\_\_\_\_ Tension\_\_\_\_ Arthritis\_\_\_\_

High Blood Pressure\_\_\_\_ Breathing Problems\_\_\_\_ Numbness in Fingers\_\_\_\_

Fainting\_\_\_\_ Loss of Smell\_\_\_\_ Weakness in Extremities\_\_\_\_

Cold Feet\_\_\_\_ Cold Hands\_\_\_\_ Unusual Bowel Patterns\_\_\_\_

Sinus Problems\_\_\_\_ Diabetes\_\_\_\_ Ingestion Problems\_\_\_\_

Menstrual Difficulties\_\_\_\_ Broken Bones/Fractures\_\_\_\_ Loss of Taste\_\_\_\_

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Muscle Spasms\_\_\_\_ Joint Pain/Swelling\_\_\_\_ Heart Disease\_\_\_\_

Stiff Neck\_\_\_\_ Lights Bother Eyes\_\_\_\_ Ulcers\_\_\_\_ Alcoholism\_\_\_\_

Fatigue\_\_\_\_ Rheumatoid Arthritis\_\_\_\_ Stroke\_\_\_\_ Osteoporosis\_\_\_\_

Sleeping Problems\_\_\_\_ Excessive Bleeding\_\_\_\_ Cancer\_\_\_\_ HIV Positive\_\_\_\_

Chest Pains/Tightness\_\_\_\_ Osteoarthritis\_\_\_\_ Ruptures\_\_\_\_

Numbness in Toes\_\_\_\_ Gall Bladder Problems\_\_\_\_ Depression\_\_\_\_

Loss of Balance\_\_\_\_ Pacemaker\_\_\_\_ Eating Disorder\_\_\_\_

Frequent Colds\_\_\_\_ Buzzing in Ears\_\_\_\_ Weight Loss/Gain\_\_\_\_

Circulation Problems\_\_\_\_ Drug Addiction\_\_\_\_ Loss of Memory\_\_\_\_

Low Blood Pressure\_\_\_\_ Coughing Blood\_\_\_\_ Seizures/Epilepsy\_\_\_\_

**Social History**

Please indicate beside each activity whether you engage in it:

Often=“O” Sometimes=“S” Never=“N”

Vigorous Exercise\_\_\_ Moderate Exercise\_\_\_ Family Pressures\_\_\_ Financial Pressures\_\_\_

Alcohol Use\_\_\_ Drug Use\_\_\_ Tobacco Use\_\_\_ Caffeine\_\_\_ High Stress Activity\_\_\_

Other Mental Stresses\_\_\_

Other(specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Condition | Father/MotherAges( ) | SpouseAge( ) | SiblingsAge( ) | ChildrenAge( ) |
| Arthritis |  |  |  |  |
| Asthma/Hay Fever |  |  |  |  |
| Back Trouble |  |  |  |  |
| Bursitis |  |  |  |  |
| Cancer |  |  |  |  |
| Constipation |  |  |  |  |
| Diabetes |  |  |  |  |
| Disc Problem |  |  |  |  |
| Emphysema |  |  |  |  |
| Epilepsy |  |  |  |  |
| Headaches |  |  |  |  |
| Heart Trouble |  |  |  |  |
| High Blood Pressure |  |  |  |  |
| Insomnia |  |  |  |  |
| Kidney Trouble |  |  |  |  |
| Liver Trouble |  |  |  |  |
| Migraine |  |  |  |  |
| Nervousness |  |  |  |  |
| Neuritis |  |  |  |  |
| Neuralgia |  |  |  |  |
| Pinched Nerve |  |  |  |  |
| Scoliosis |  |  |  |  |
| Sinus Trouble  |  |  |  |  |
| Stomach Trouble |  |  |  |  |
| Other |  |  |  |  |

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives locally, as some hereditary conditions are affected by similar climate.

If any of the above family members are deceased, please list their age at death and cause:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Assignment of Benefits/Authorization**

I hereby acknowledge that I am receiving (or about to receive) health care services from Cannon Chiropractic PLLC, and that the clinic providing the services is willing to wait for payment for the services, provided that there continues to be a reasonable change that payment will be made either by insurance proceeds or out of the settlement of a liability claim. \_\_\_\_\_\_\_\_\_\_(Initial)

**Authorization to File Insurance**

I authorize Cannon Chiropractic PLLC to release any information it deems appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred for services rendered to me by Cannon Chiropractic PLLC or any member of the staff acting on the clinic’s behalf. \_\_\_\_\_\_\_\_\_\_(Initial)

**Assignment of Benefits**

I authorize the direct payment to Cannon Chiropractic PLLC of any sum I now or hereafter owe the clinic by any insurance company obligated to reimburse me, and to my attorney, out of proceeds of any settlement of my case for the charges for services rendered or otherwise obligated to make payment to me or Cannon Chiropractic PLLC based in whole or in part upon the charges made for services rendered. In the event any insurance company obligated by contractual agreement to make payment to Cannon Chiropractic PLLC or me for the charges made for services refuses to make sure payment upon demanded by the clinic, I hereby assign and transfer to Cannon Chiropractic PLLC the cause of action that exists in my favor against any such company. I authorize Cannon Chiropractic PLLC to prosecute said action either in my name or the name of the clinic as it deems necessary, and further authorize Cannon Chiropractic PLLC to compromise, settle or otherwise resolve said claim as it deems necessary. \_\_\_\_\_\_\_\_\_\_(Initial)

**Financial Agreements**

If an insurance company obligated to pay me or Cannon Chiropractic PLLC the charges for services rendered refuses to pay upon demand by the clinic, or if there is no insurance company so obligated, then I will pay for services rendered by Cannon Chiropractic PLLC. I will pay my account in full immediately, or I will keep my account current. If I have a liability claim and my attorney refuses to protect the interest of Cannon Chiropractic PLLC, or if I have not engaged the services of an attorney, I hereby promise to pay my bill in full within ten (10) days from the date my liability claim is settled or after the passage of two (2) months from the date of my last treatment, whichever comes first. \_\_\_\_\_\_\_\_\_\_(Initial)

**Late Payments**

I will be allowed eight (8) weeks to pay Cannon Chiropractic PLLC the balance of my bill. If I do not pay within this time period, **the clinic will add a 1.5% late fee to my balance monthly.** I agree to pay all cost of collections if my balance becomes delinquent, including attorney fees and all court costs if a lawsuit is filed against me. \_\_\_\_\_\_\_\_\_\_(Initial)

**Collection Agencies**

In the event that your account is placed with a Collection Agency, a collection fee may be added to your account and shall become part of the total amount due. You will be responsible for any and all cost of collection including attorney fees and court costs. You agree, that in order for us to service your account or to collect any amount you may owe, we and our collection agencies may contact you by telephone at any telephone number associated with your account, including wireless telephone, which could result in charges to you. We and our collection agencies may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. \_\_\_\_\_\_\_\_\_\_(Initial)

**If Applicable-Lifetime Authorization to file Medicare**

I request that payments authorized Medicare benefits be made either to me or on behalf to Cannon Chiropractic PLLC for any services furnished to me by Cannon Chiropractic PLLC. I authorize any holder of medical information about me to be released to Health Care Financing and its agents any information needed to determine these benefits or the benefits payable for related services. \_\_\_\_\_\_\_\_\_\_(Initial)

**Authorization to Leave Message**

I hereby authorize Cannon Chiropractic PLLC to leave a message at my home/cell regarding pending appointments and/or tests. \_\_\_\_\_\_\_\_\_\_(Initial)

**Patient or Responsible Party**

BY SIGNING BELOW, I ACKNOWLEDGE I HAVE READ AND UNDERSTAND THE ABOVE.

Patient/Responsible Party:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (PLEASE PRINT)

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

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

 During your care as a patient at Cannon Chiropractic PLLC, 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 insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
* Your name, address, phone number, and your health 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 home to receive an appointment reminder, a message may be left on your answering machine. 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 the 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 case of 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 we are ordered by the courts or another appropriate agency.

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

 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 healthcare 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 if the information remains in our files. In addition, you have the right to request an amendment for your health information. Requests to inspect, copy or amend your health-related information should be provided in writing.

 We are required by the state and federal law to maintain the privacy of your patient file and the 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 the law to abide to the terms of these notices while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy practices, we will notify you in writing as soon as possible following the changes. 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 this privacy notice may be subject to re-disclosure by the person to whom we provide the information and no longer be protected by federal rules.

 If you have a complaint regarding our privacy notice, our privacy practices, or any aspect of our privacy activities, you should direct your complaint to Dr. Jayson Cannon, D.C.

 If you would like further information about our policies and practices, please contact us.

This notice is effective as of 01/02/2018. This notice and any alterations or amendments made hereto will expire seven (7) years after the date which

the record was created. My signature acknowledges that I have received a copy of this notice.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Name (PRINT) Signature Date

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Personal Representative (PRINT) Personal Representative Signature Date

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Relationship to patient, if minor or being represented by another party

**Consent to Examine and Treat**

 The undersigned consents to any examination (x-ray or otherwise) including, but not limited to, physical, orthopedic and neurological evaluation, visual inspection and palpation.

 The undersigned also consents to observation of therapeutic or diagnostic procedures by staff personnel or medical personnel in training as permitted by the attending practitioner and allowed by clinic policy. Treatment procedures that may be used in your treatment include, but not limited to, manipulative therapy, joint mobilization, myofascial release, trigger-point therapy, ultrasound, diathermy, electrical stimulation, rehabilitate exercise, and massage.

 Cases will be managed with all due concern and with the evaluation of response to previous care provided. Home care instructions will be given as necessary to enhance your treatment program. Compliance with the recommendations for home care and follow-up care is necessary for the resolution of your complaint.

 Because of modern techniques and equipment, examinations and therapeutic procedures carry with them a low risk of complication. Even though problems seldom arise during these procedure, risk of complication 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 remarkably safe and effective, understand that occasionally there may be adverse reactions that occur. Although the chances of experiencing any of these complications are extremely small, it is the practice of this office to fully inform and educate our patients. These complications 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. No guarantee or warranty for a specific care or result is implied by the acceptance of your case. All patients respond differently to the treatment procedures and each case must by evaluated separately.

 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 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.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (PRINT)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature

\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness