



116 N Dodge Street, Unit 2
Burlington, WI 53105
p. 262.767.0500
f. 262.767.1534

Patient Information

Patient Name: _____
LAST FIRST M.I.

Address: _____
STREET ADDRESS CITY STATE ZIP

Birthdate: ____/____/____ Age: ____ Social Security #: ____-____-____

Phone: (home) _____ (cell) _____

Email: _____

Emergency Contact: _____ Relationship: _____ Emergency Contact Phone: _____

Marital Status: Single Married Widowed Divorced

Gender : Female Male Number of children/ages: _____

Work Status: Full Time Part Time Homemaker Unemployed Retired Student

Employer Name: _____ Employer City, State: _____

Occupation: _____ Years Employed: _____ Physical Work Duties: _____

Have you ever had chiropractic care before? Yes No

If yes, please tell us the doctor's name _____ Were you pleased with your care? Yes No

Please share any relevant details about previous care _____

How did you find out about our office? _____

Is this appointment related to an auto accident or work injury? Yes No If yes, please fill out the Auto/WC Questionnaire

Are you receiving care from other health professionals? Yes No

If yes, please name them and their specialty _____

Who is your family's primary care physician? _____

Are you seeking chiropractic for Health maintenance/optimization Health problems Both

Health Insurance Information Please present your Insurance Card to the front desk.

Policy Holder's Information— Full Name: _____ Birth Date: ____/____/____
LAST FIRST M.I.

Social Security #: ____-____-____ Relationship to you: _____

Current Health

Please list any drugs/medications or vitamins/herbs/homeopathics/other you are taking/have taken _____

What health condition brings you to our office? Be specific. _____

When did the symptoms first begin? _____

Was the onset? Sudden Gradual Post-Injury

Which best describes the frequency of your discomfort?

Constant (76%-100%) Frequent (51%-75%) Occasional (26%-50%) Intermittent (0%-25%)

Rate your symptoms? Mild Moderate Severe Intolerable

Which phrases best describe *changes* in your discomfort during the day? (select one or more)

- it is worse in the morning
- it is worse in the afternoon
- it is worse at night
- it changes with the weather
- it does not change
- it is worse with activity

Is the condition Getting Worse Improving Not Changing

What makes the problem better? _____

What makes the problem worse? _____

Have you ever had a similar condition? Yes No

Please explain _____

What activities are limited or affected by the condition? (select one or more)

- | | | | |
|---|---|-----------------------------------|--|
| <input type="checkbox"/> Bending | <input type="checkbox"/> Bowel Movements | <input type="checkbox"/> Coughing | <input type="checkbox"/> Daily Routine |
| <input type="checkbox"/> Driving | <input type="checkbox"/> Changing Positions | <input type="checkbox"/> Lifting | <input type="checkbox"/> Lying down |
| <input type="checkbox"/> Pulling | <input type="checkbox"/> Pushing | <input type="checkbox"/> Reading | <input type="checkbox"/> Sitting |
| <input type="checkbox"/> Sleeping | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Standing | <input type="checkbox"/> Turning my head |
| <input type="checkbox"/> Urination | <input type="checkbox"/> Walking | <input type="checkbox"/> Working | |
| <input type="checkbox"/> Other (please describe): _____ | | | |

Do your symptoms travel to any other area? _____

Health History

Have you ever been checked for vertebral subluxations? Yes No Don't Know

Has a physician ever diagnosed you with allergies? If so, please specify what type: _____

Please list any broken bones/surgeries/hospitalizations with dates: _____

Have you been struck unconscious? Yes No Have you been in an auto accident? Yes No If yes, list date: _____

Where applicable, specify the approximate date of you most recent: (month/year)

Physical exam: ____/____

Dental x-rays: ____/____

Spinal x-ray: ____/____

CT scan: ____/____

MRI: ____/____

Other scans or x-rays: ____/____

Female Only

- | | | |
|---|------------------------------|-----------------------------|
| Are you pregnant? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you nursing? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you taking birth control? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you experience painful periods? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have irregular cycles? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have breast implants? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you perform regular self-breast exams? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you take HRT? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Social History & Life Choices

- | | | | | |
|---------------------------------------|--------------------------------|---------------------------------|---------------------------------------|--------------------------------|
| Alcohol | <input type="checkbox"/> Daily | <input type="checkbox"/> Weekly | <input type="checkbox"/> Occasionally | <input type="checkbox"/> Never |
| Diet Food Products | <input type="checkbox"/> Daily | <input type="checkbox"/> Weekly | <input type="checkbox"/> Occasionally | <input type="checkbox"/> Never |
| Energy Products or OTC Stimulants | <input type="checkbox"/> Daily | <input type="checkbox"/> Weekly | <input type="checkbox"/> Occasionally | <input type="checkbox"/> Never |
| Fresh & Homemade Foods | <input type="checkbox"/> Daily | <input type="checkbox"/> Weekly | <input type="checkbox"/> Occasionally | <input type="checkbox"/> Never |
| Soft Drinks | <input type="checkbox"/> Daily | <input type="checkbox"/> Weekly | <input type="checkbox"/> Occasionally | <input type="checkbox"/> Never |
| Water | <input type="checkbox"/> Daily | <input type="checkbox"/> Weekly | <input type="checkbox"/> Occasionally | <input type="checkbox"/> Never |
| Caffeine Drinks & Products | <input type="checkbox"/> Daily | <input type="checkbox"/> Weekly | <input type="checkbox"/> Occasionally | <input type="checkbox"/> Never |
| Drugs | <input type="checkbox"/> Daily | <input type="checkbox"/> Weekly | <input type="checkbox"/> Occasionally | <input type="checkbox"/> Never |
| Exercise | <input type="checkbox"/> Daily | <input type="checkbox"/> Weekly | <input type="checkbox"/> Occasionally | <input type="checkbox"/> Never |
| Processed, Packaged, Restaurant Foods | <input type="checkbox"/> Daily | <input type="checkbox"/> Weekly | <input type="checkbox"/> Occasionally | <input type="checkbox"/> Never |
| Tobacco | <input type="checkbox"/> Daily | <input type="checkbox"/> Weekly | <input type="checkbox"/> Occasionally | <input type="checkbox"/> Never |
| Ice Pack Usage | <input type="checkbox"/> Daily | <input type="checkbox"/> Weekly | <input type="checkbox"/> Occasionally | <input type="checkbox"/> Never |

Detailed Review of Systems

CARDIOVASCULAR

 N/A

<u>Past</u>	<u>Present</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Poor Circulation
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Aortic Aneurysm
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain
<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol
<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain
<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heartbeat
<input type="checkbox"/>	<input type="checkbox"/>	Swelling of Legs
<input type="checkbox"/>	<input type="checkbox"/>	Stroke

GENITOURINARY

 N/A

<u>Past</u>	<u>Present</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	<input type="checkbox"/>	Lower Side Pain
<input type="checkbox"/>	<input type="checkbox"/>	Burning Urination
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/>	Blood in Urine
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones
<input type="checkbox"/>	<input type="checkbox"/>	Bed Wetting/Enuresis
<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems
<input type="checkbox"/>	<input type="checkbox"/>	Rectal Prolapse

HEMATOLOGICAL/LYMPHATIC

 N/A

<u>Past</u>	<u>Present</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Lymphoma
<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Leukemia
<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis
<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

RESPIRATORY

 N/A

<u>Past</u>	<u>Present</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath
<input type="checkbox"/>	<input type="checkbox"/>	Upper Resp Infection
<input type="checkbox"/>	<input type="checkbox"/>	Cold/Flu
<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	<input type="checkbox"/>	Cough/Wheezing
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema
<input type="checkbox"/>	<input type="checkbox"/>	RSV
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis

EAR/NOSE/THROAT

 N/A

<u>Past</u>	<u>Present</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Sinus Congestion
<input type="checkbox"/>	<input type="checkbox"/>	Sinus Infection
<input type="checkbox"/>	<input type="checkbox"/>	Nosebleed
<input type="checkbox"/>	<input type="checkbox"/>	Sore Throat
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Swallowing
<input type="checkbox"/>	<input type="checkbox"/>	Ear Ache
<input type="checkbox"/>	<input type="checkbox"/>	Ear Infections
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Gums

EYES

 N/A

<u>Past</u>	<u>Present</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	Double Vision
<input type="checkbox"/>	<input type="checkbox"/>	Blurred Vision
<input type="checkbox"/>	<input type="checkbox"/>	Red, Itchy (Allergy)

ALLERGIC/IMMUNOLOGICAL

 N/A

<u>Past</u>	<u>Present</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Seasonal Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Food Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Environmental Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Allergy Shots
<input type="checkbox"/>	<input type="checkbox"/>	Cortisone Use
<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Hives
<input type="checkbox"/>	<input type="checkbox"/>	Weak Immune System

GASTROINTESTINAL

 N/A

<u>Past</u>	<u>Present</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Pancreatitis
<input type="checkbox"/>	<input type="checkbox"/>	Acid Reflux
<input type="checkbox"/>	<input type="checkbox"/>	Bowel Problems
<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	Upset Stomach
<input type="checkbox"/>	<input type="checkbox"/>	Gas Pains
<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder Problems
<input type="checkbox"/>	<input type="checkbox"/>	Liver Problems
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	Nausea/Vomiting
<input type="checkbox"/>	<input type="checkbox"/>	Poor Appetite
<input type="checkbox"/>	<input type="checkbox"/>	Bloody Stools
<input type="checkbox"/>	<input type="checkbox"/>	Crohn's Disease
<input type="checkbox"/>	<input type="checkbox"/>	Hiatal Hernia

MUSCULOSKELETAL

 N/A

<u>Past</u>	<u>Present</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Hip Dislocation
<input type="checkbox"/>	<input type="checkbox"/>	Torticollis
<input type="checkbox"/>	<input type="checkbox"/>	Poor Posture
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain
<input type="checkbox"/>	<input type="checkbox"/>	Back Pain
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Joint Stiffness
<input type="checkbox"/>	<input type="checkbox"/>	Muscle Weakness
<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	<input type="checkbox"/>	Broken Bones
<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement
<input type="checkbox"/>	<input type="checkbox"/>	Gout

NEUROLOGICAL

 N/A

<u>Past</u>	<u>Present</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Tic Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Head Injury
<input type="checkbox"/>	<input type="checkbox"/>	Brain Aneurysm
<input type="checkbox"/>	<input type="checkbox"/>	Numbness/Tingling
<input type="checkbox"/>	<input type="checkbox"/>	Pinched Nerves
<input type="checkbox"/>	<input type="checkbox"/>	Radiating Pain
<input type="checkbox"/>	<input type="checkbox"/>	Sciatica

NEUROLOGICAL CONTINUED

<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's Disease
<input type="checkbox"/>	<input type="checkbox"/>	Carpal Tunnel
<input type="checkbox"/>	<input type="checkbox"/>	Balance/Coordination
<input type="checkbox"/>	<input type="checkbox"/>	ADHD/ADD/SPD
<input type="checkbox"/>	<input type="checkbox"/>	Autism/Spectrum
<input type="checkbox"/>	<input type="checkbox"/>	Migraine Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Bell's Palsy
<input type="checkbox"/>	<input type="checkbox"/>	Poor Fine/Gross Motor
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Inflammation
<input type="checkbox"/>	<input type="checkbox"/>	Trigeminal Neuralgia
<input type="checkbox"/>	<input type="checkbox"/>	Ear Ringing/Tinnitus
<input type="checkbox"/>	<input type="checkbox"/>	Toe Walking
<input type="checkbox"/>	<input type="checkbox"/>	Auditory Processing
<input type="checkbox"/>	<input type="checkbox"/>	Sinus Headache
<input type="checkbox"/>	<input type="checkbox"/>	Tension Headache
<input type="checkbox"/>	<input type="checkbox"/>	Vertigo/Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Sensory Integration

ENDOCRINE

 N/A

<u>Past</u>	<u>Present</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Hyperthyroid Issues
<input type="checkbox"/>	<input type="checkbox"/>	Hypothyroid Issues
<input type="checkbox"/>	<input type="checkbox"/>	Type 1 Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Type 2 Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Hair Loss
<input type="checkbox"/>	<input type="checkbox"/>	Menopausal
<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Problems
<input type="checkbox"/>	<input type="checkbox"/>	Hot Flashes
<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis
<input type="checkbox"/>	<input type="checkbox"/>	PCOS
<input type="checkbox"/>	<input type="checkbox"/>	Hashimoto
<input type="checkbox"/>	<input type="checkbox"/>	Graves

PSYCHIATRIC

 N/A

<u>Past</u>	<u>Present</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Unusual Stress
<input type="checkbox"/>	<input type="checkbox"/>	OCD
<input type="checkbox"/>	<input type="checkbox"/>	Bipolar Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Seasonal Affective (SAD)
<input type="checkbox"/>	<input type="checkbox"/>	Mood Swings
<input type="checkbox"/>	<input type="checkbox"/>	Social Anxieties
<input type="checkbox"/>	<input type="checkbox"/>	Memory Loss
<input type="checkbox"/>	<input type="checkbox"/>	Night Tremors

CONSTITUTIONAL

 N/A

<u>Past</u>	<u>Present</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss/Gain
<input type="checkbox"/>	<input type="checkbox"/>	Energy Level Low
<input type="checkbox"/>	<input type="checkbox"/>	Energy Level High
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Sleeping
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	General Malaise
<input type="checkbox"/>	<input type="checkbox"/>	Compulsive Behavior
<input type="checkbox"/>	<input type="checkbox"/>	Behavior Issues
<input type="checkbox"/>	<input type="checkbox"/>	Learning Disabilities
<input type="checkbox"/>	<input type="checkbox"/>	Speech Delays
<input type="checkbox"/>	<input type="checkbox"/>	RLS
<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy/Fertility
<input type="checkbox"/>	<input type="checkbox"/>	Obesity

Authorizations and Releases

HEALTH CARE AUTHORIZATION FORM

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my treatment, payment of my bills or in the performance of health care operations of this chiropractic office. A copy of our notice is attached, and we encourage you to read it and request your own copy if you would like one.

This Notice of Privacy Practices also describes my rights and the duties of the chiropractic office with respect to my protected health information. I hereby give permission to Core Chiropractic & Wellness Center (CCWC) to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS:

- I give permission to CCWC to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information.
- If CCWC contacts me by phone, I give them permission to leave a phone message on my answering machine or voicemail.
- I give permission to CCWC to use any testimonial written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochure, on their website or in ads in print media.
- I give CCWC permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with doctor at any time in private, the doctor will provide a room for these conversations.
- By signing this form, you are giving CCWC permission to use and disclose your protected health information in accordance with the directives listed above. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. This authorization will remain in effect for the duration of my care at CCWC plus 7 years or until revoked by me.

RIGHT TO REVOKE AUTHORIZATION:

You have the right to revoke this authorization, in writing, at any time. However, your written request to revoke this authorization is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this authorization by mailing or hand delivering a written notice to the Privacy Official of CCWC. The written notice must contain the following information:

- Your name, Social Security number and date of birth;
- A clear statement of your intent to revoke this authorization;
- The date of your request; and
- Your signature.

The revocation is not effective until it is received by the Privacy Official.

This authorization is requested by CCWC for its own use/disclosure of PHI. *(Minimum necessary standards apply.)*

I have the right to refuse to sign this authorization. If I refuse to sign this authorization, CCWC will not refuse to provide care. However, it will not be possible for CCWC to file third party billing on my behalf and I will be responsible for 1) payment in full at the time services are provided to me 2) scheduling my own appointments since CCWC will be unable to contact me 3) all contact with CCWC regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.*

I have the right to inspect or copy, within boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me. I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

Signature _____ Date _____

Consent to Professional Treatment (Informed Consent)

We encourage and support a **shared decision-making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgeably give or withhold your consent.

- **Chiropractic** is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.
- **Adjustments** are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.
- A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.
- The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them. Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition, there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence

does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE CORE CHIROPRACTIC & WELLNESS CENTER TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT. DATED THIS ____ DAY OF _____, 20__

Signature _____

Parental Consent for Minor Patient:

Patient Name: _____ DOB: _____ Patient Age: _____

Printed name of person legally authorized to sign for the above named patient: _____

Signature: _____ Relationship to Patient: _____

In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.

Signature _____ Date _____

Consent to Perform and Interpret X-rays

The patient consents to the performance of x-rays as deemed necessary by the doctor of this office. The patient acknowledges that certain risks are associated with x-rays. The patient hereby states that they have no known limitations that would forbid the taking of x-rays. The patient further agrees that this office may seek outside interpretation of patient x-rays by a qualified professional not employed by this office. The patient agrees to any additional fees associated with this service and assigns benefits to be paid directly to that professional by your third-party payer.

INITIAL _____

Assignment of Benefits and Release of Records

The patient hereby assigns benefits to be paid directly to this provider by all of their third party payers. This assignment is irrevocable. Failure to fulfill this obligation will be considered a breach of contract between the patient and this office. Understand that your insurance policy is a contract between you and the insurance company. Any claim that is denied is the responsibility of the patient. I understand that any insurance payment sent to me will be part of my balance due, and therefore it is my responsibility to forward such payment to Core Chiropractic & Wellness Center, LLC. The patient authorizes this office to release any information required by a third party payer necessary for reimbursement of charges incurred.

INITIAL _____

Financial Obligation and Appointment Policy

The patient accepts full financial responsibility for services rendered by this practice. This office reserves the right to charge fair market value for missed appointments or appointments canceled without any advanced notification required by this office. Out of consideration for other patients that may want to schedule, we require a minimum of 12 hours advanced notice when changing, rescheduling or canceling an appointment to avoid a charge of \$25. Payment in full is required for all services at the time of visit, unless alternative arrangements have been agreed to in advance. Patient accepts full responsibility for any fees incurred, including but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collection of past due accounts. Should you choose to discontinue care early, the account is refigured on a per visit basis (without any discounts) and you either a) are responsible for the outstanding balance or b) will receive a refund on the care not yet received. Patient should direct any questions regarding this financial obligation and appointment policy to the clinic manager or doctor. The patient further authorizes the practice to retain credit card, debit card, checking account or other payment source(s) supplied by patient to the practice for current and future charges, when incurred.

INITIAL _____

Signature _____ Date _____

Our software enables us to send appointment reminders via text message or email. Please check below which method you prefer.

Text Message

Phone Number: _____

Cell Phone Provider: _____ Ex. Verizon, US Cellular, etc.

Email

Email Address: _____