ChiropracticPlace
Family Wellness Centers

PATIENT QUESTIONNAIRE

(PLEASE PRINT)

New Patient ☐
Reactivate ☐
Other ☐

Full Legal Name _____ *Birth Date _____
First Middle Last

Address _____
Street / PO Box City State Zip

Home Phone _____ Mobile Phone _____ Email Address _____

Would you like to receive Email or Text reminders for appointments? ☐ No ☐ Yes

Employer _____ Work Phone _____ Student ☐ No ☐ Yes - ***(see also page 4)***

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Spouse Name _____ Phone # _____ Spouse Employer _____

Emergency Contact _____ Phone # _____ Relationship _____

Did anyone refer you to our office? ☐ No ☐ Yes – Who _____

HISTORY OF PRESENTING ILLNESS/INJURY *(see also page 3)*

What are your symptoms? _____

Date your symptoms began? _____

How did it occur? _____ ☐ *Work Related ☐ *Auto Accident ***(*Provide COPIES of all Documents)***

Have you missed any work? ☐ No ☐ Yes - How Much? _____ hours / days / weeks / months

Do you have any recent X-rays of that area(s)? ☐ No ☐ Yes – Facility where taken? _____

PAST MEDICAL HISTORY *(see also page 4)*

Have you received care from a Chiropractor before? ☐ No ☐ Yes – Doctor/Clinic _____

INSURANCE COVERAGE

Do you have Insurance? ☐ No ☐ *Yes - ***Provide COPY of Insurance Card(s)***

PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Co _____	Insurance Co _____
Insurance Phone _____	Insurance Phone _____
Policy/Subscriber ID# _____	Policy/Subscriber ID# _____
Group# _____	Group# _____
Policyholder Name _____	Policyholder Name _____
Policyholder Relationship to You _____	Policyholder Relationship to You _____
Policyholder Date of Birth _____	Policyholder Date of Birth _____
Policyholder Employer _____	Policyholder Employer _____

OFFICE USE ONLY:

Patient Acct # _____

Appointment Date _____ *Time* _____ *am / pm*

☐ *Insurance Card scanned* ☐ *Driver's Licensed scanned* ***Staff Initials*** _____

PATIENT DEMOGRAHICS ***(*Required per Federal Guidelines)***

SSN# _____-_____-_____

***Gender** ☐ Male ☐ Female

Ethnicity** ***(select one): ☐ Hispanic ☐ Not Hispanic

Race** ***(select one):

☐ Alaska Native ☐ Asian ☐ Native Hawaiian ☐ White/Caucasian
☐ American Indian ☐ Black/African American ☐ Other Pacific Islander ☐ Other: _____

Language** ***(select one):

☐ English ☐ Hmong ☐ Lao ☐ Spanish ☐ Vietnamese ☐ Other: _____

***Allergies:** ☐ *None -OR- List Below:*

Drug/Medication (ADR):	***Food:***	***Other Allergies: (e.g.-animals, pollen, latex, etc)***

***Smoking Status (Individuals age 13 years and older):**

☐ Smoker-Daily (___Packs/day or ___Cigarettes/day – for: ___Years or Since: _____/_____/_____)
☐ Smoker-Some Days (NOT Daily)
☐ Former (___Packs/day or ___Cigarettes/day – from: Age ____ to Age ____)
☐ Never
☐ Smoker-Current Status Known

***Current Prescription Medications** *Name of Prescription:*	*Dose (mg, mL, etc)*	*Form (Tab, Caps, etc)*	*Duration (# times per day, wk, mo)*	***-OR-***	*Chronic*	*Unknown*
			_____x per_____		___	___
			_____x per_____		___	___
			_____x per_____		___	___
			_____x per_____		___	___
			_____x per_____		___	___
			_____x per_____		___	___
			_____x per_____		___	___
			_____x per_____		___	___
			_____x per_____		___	___
			_____x per_____		___	___
			_____x per_____		___	___
			_____x per_____		___	___
			_____x per_____		___	___
			_____x per_____		___	___

OFFICE USE ONLY:** ***(Vitals age 2 yrs+)

Height _____ *inches;* *Weight* _____ *lbs;* *Pulse* _____; *Respir* _____; *Temp* _____;

Blood Pressure _____/_____ *(Sitting / Standing / Supine)* ***Staff Initials:*** _____

HISTORY OF PRESENT ILLNESS / INJURY *(see also page 1)*

CHIEF COMPLAINT(S)

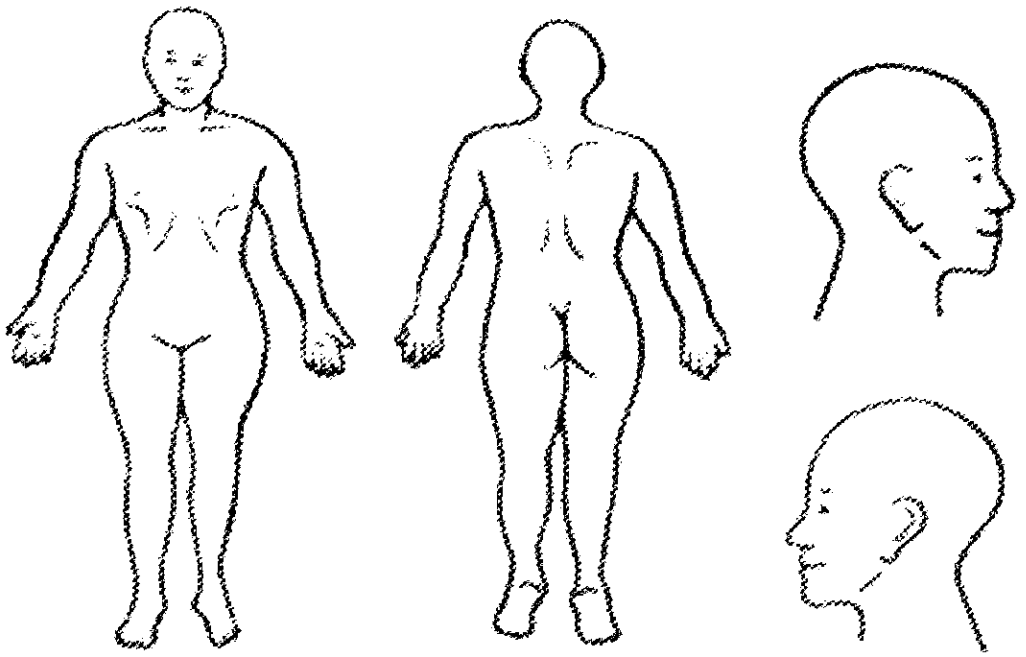
FILL OUT THIS SECTION AS ACCURATELY AS POSSIBLE. MARK THE AREA WITH THE DESCRIBED SENSATION USING THE APPROPRIATE SYMBOLS FROM THE LEFT. RATE YOUR PAIN ON THE SCALE BELOW FROM 0 TO 100 WITH 0 BEING NO PAIN AND 100 BEING INTOLERABLE PAIN. IF THERE IS MORE THAN ONE AREA OF DISCOMFORT, PLEASE RATE THE PAIN 0 TO 100 NEXT TO EACH AREA AS APPROPRIATE.

X X X	Burning Pain
(((	Aching Pain
0 0 0	Pins & Needles
- - - -	Numbness
: : :	Sharp Pain

__Constant
__Comes/Goes

__Getting Better
__Getting Worse
__Staying Same

Better:	Worse:
___ AM	___
___ MID-DAY	___
___ PM	___



NO PAIN **PAIN SCALE:** **INTOLERABLE**

0___5___10___15___20___25___30___35___40___45___50___55___60___65___70___75___80___85___90___95___100

What Makes Condition BETTER?

Head / Neck: ☐ Heat ☐ Cold ☐ Meds ☐ Chiropractic ☐ Other: _____
Mid Back: ☐ Heat ☐ Cold ☐ Meds ☐ Chiropractic ☐ Other: _____
Low Back: ☐ Heat ☐ Cold ☐ Meds ☐ Chiropractic ☐ Other: _____
Shoulder, Arm, Wrist, Hand: ☐ Heat ☐ Cold ☐ Meds ☐ Chiropractic ☐ Other: _____
Hip, Leg, Ankle, Foot: ☐ Heat ☐ Cold ☐ Meds ☐ Chiropractic ☐ Other: _____
Other: _____ ☐ Heat ☐ Cold ☐ Meds ☐ Chiropractic ☐ Other: _____

What Makes Condition WORSE?

Head / Neck: _____
Mid Back: _____
Low Back: _____
Shoulder, Arm, Wrist, Hand: _____
Hip, Leg, Ankle, Foot: _____
Other: _____ _____

Indicate your Ability to Perform the Following Activities of Daily Living. Please use the following codes:

U – Unable **L – Limited** **P – Painful** **D – Difficult** **N – Normal** **H – Haven't Tried**

___Lying on Back	___ Dressing Self	___Lifting	___Kneeling	___ Twist/Turn – LEFT / RIGHT
___ Lying on Sides	___ Stooping	___Gripping	___Bending Forward	___Sitting/Driving/Riding
___ Lying on Stomach	___ Pushing/Pulling	___Standing	___Get In/Out of Car	___ Using Computer
___Turning Over in Bed	___ Reaching	___Walking	___Sexual Activity	___ Using Stairs/Ladder

___ Cough/Sneeze/Grunt – *(if painful, where* _____*)*

___ Sleeping - *(# times wake up* _____ *; # pillows* _____*; position sleep in:* _____*)*

PAST MEDICAL HISTORY *(see also page 1)*

FEMALES: Are You Pregnant? ☐ No ☐ Yes Due Date:_____ Doctor: _____

Date of Last Gynecological & Breast Exam: _____

MALES: Date of last Prostate & Testicular Exam: _____

How often have you had this condition that you are seeing us today for? ☐ Never ☐ 1-3 Times ☐ 4 or More Times

Have you received care from a Chiropractor before? ☐ No ☐ Yes *(see also page 1)*

Have you seen a Medical Doctor for this Condition? ☐ No ☐ Yes – Doctor/Clinic _____

Do you have any other Health Conditions? (Check all that apply):

☐ Diabetes ☐ High Blood Pressure ☐ High Cholesterol ☐ Asthma ☐ IBS/Colitis ☐ Cancer
☐ Arthritis ☐ Infertility Issues ☐ Other: _____

Describe any major Illnesses, Injuries, Falls, Hospitalizations, Accidents or Surgeries:

DATE	DOCTOR	CONDITION(S)	RESULTS	
_____	_____	_____	☐ COMPLETE RECOVERY	☐ COMPLICATIONS
_____	_____	_____	☐ COMPLETE RECOVERY	☐ COMPLICATIONS
_____	_____	_____	☐ COMPLETE RECOVERY	☐ COMPLICATIONS
_____	_____	_____	☐ COMPLETE RECOVERY	☐ COMPLICATIONS
_____	_____	_____	☐ COMPLETE RECOVERY	☐ COMPLICATIONS
_____	_____	_____	☐ COMPLETE RECOVERY	☐ COMPLICATIONS

SOCIAL HEALTH HISTORY

Student ☐ Part-Time ☐ Full-Time ☐ N/A

Occupation _____ Hrs per Week _____

Recreational Activities/Hobbies _____

Do you Exercise? ☐ No ☐ Yes How Often? _____ In What Way? _____

Do you consume Caffeine? ☐ No ☐ Yes How Much? _____ How Often? _____

Do you consume Alcohol? ☐ No ☐ Yes How Much? _____ How Often? _____

FAMILY HEALTH HISTORY

List any current or past health conditions of your family members (if deceased, indicate at what age and from what?)

MOTHER: _____

FATHER: _____

BROTHERS: _____ How Many_____

SISTERS: _____ How Many_____

CHILDREN: _____ How Many_____

SYSTEM REVIEW QUESTIONS

Have you had any problems with the following areas Now or in the Past? (**Y** = Yes and **N** = No)

___**EYES** (Glasses, Contacts, Cataracts, Glaucoma, Etc)
___**EARS, MOUTH, NOSE, THROAT** (Hearing Loss, Sinus, Etc)
___**CARDIOVASCULAR** (Heart, High BP, High Cholesterol, Etc)
___**RESPIRATORY** (Lungs, Breathing, Asthma, COPD, Etc)
___**NEUROLOGICAL** (Nerve Issues, Weakness, Numbness, Etc)
___**ENDOCRINE** (Thyroid, Hormonal, Imbalances, Liver, Etc)
___**GASTRO-INTESTINAL** (Acid Reflux, Ulcers, Gall Bladder, IBS, Etc)
___**GENITO-URINARY** (Male/Female Reproductive, Kidney, Bladder, Etc)
___**MUSCULOSKELETAL** (Breaks, Arthritis, Osteoporosis, Discs, Etc)
___**SKIN** (Rashes, Skin Cancer, Dryness, Psoriasis, Eczema, Hair, Etc)
___**PSYCHIATRIC** (Anxiety, Depression, Bipolar, ADD/ADHD, Etc)
___**OTHERS:** _____

Please describe in more detail: _____

NOTES

PAIN & FUNCTIONAL OUTCOME ASSESSMENTS

Main Area of Complaint: _____

OVAS: On a scale of 0–100 where 0 is no pain and 100 is severe pain please fill in the blanks.

BEST: _____ WORST: _____ NOW: _____ USUAL: _____

PATIENT SPECIFIC FUNCTION AND PAIN SCALE: On a scale of 0-10 where 0 is normal and 10 is unable, please fill in 3 of the blanks.

PUSHING: _____ LIFTING: _____ SITTING: _____ WALKING: _____

STAIRS: _____ STANDING: _____ READING: _____ USING COMPUTER: _____

DRIVING: _____ SLEEPING: _____ GRIPPING: _____ EXERCISING: _____

NECK/BACK BOURNEMOUTH QUESTIONNAIRE

Date:					
Over the past week, on average, how would you rate your neck/back pain? 0 – no pain, 10 – worst pain					
Over the past week, how much has your neck/back pain interfered with your daily activities (housework, dressing, walking, climbing stairs, getting in/out of bed/chair)? 0 – no interference, 10 – unable to carry out activity					
Over the past week, how much has your neck/back pain interfered with your ability to take part in recreational, social and family activities? 0 – no interference, 10 – unable to carry out activity					
Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating or relaxing) have you been feeling? 0 – not at all anxious, 10 – extremely anxious					
Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling? 0 – not at all depressed, 10 – extremely depressed					
Have you discussed the depression score & offered referral for counseling.					
Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck/back pain? 0 – have made it no worse, 10 – have made it much worse					
Over the past week, how much have you been able to control (reduce/help) your back pain on your own? 0 – completely control it, 10 – no control whatsoever					
Total Points					
Normal = 0% Score: Total points/70x100 = total %	%	%	%	%	%

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Family Wellness Centers

INFORMED CONSENT: PHYSICAL THERAPY MODALITIES

I hereby request and consent to receiving Physical Therapy Modalities, Exercise Therapies and any other Supportive Therapies as deemed appropriate by the Doctors of Chiropractic and performed by the Doctors of Chiropractic or Licensed Support Staff employed by, associated with, or serving as back-up support for, Chiropractic Place now or in the future.

I understand and am informed that with Chiropractic care, as in the practice of medicine and all other health care modalities, results are not guaranteed and there is no promise of a cure. I further understand and am informed that, while Chiropractic care is remarkably safe and effective and provides many patients with benefits including pain relief and enhanced health, there can be associated risks, just as in the practice of medicine. Potential risks include, but are not limited to: soreness, fractures, disc injuries, rib injury, physiotherapy burns, soft tissue injury, stroke, dislocations and sprains. With that understanding, I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment, which is in my best interest, during the course of the procedure the doctor has deemed appropriate at that time based upon the facts then known.

I also understand that there are treatment options available for my condition other than Chiropractic procedures. These treatment options include, but are not limited to: rest; self-administered care; over-the-counter analgesics; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and pain killers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I acknowledge that the Doctor of Chiropractic has discussed with me the following items:

- Explanation of my current condition;
- Proposed Chiropractic procedures;
- Risks of not receiving or undergoing any treatments or procedures.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content. I intend this consent to cover the entire course of treatment for my current condition and for any future condition(s) for which I seek treatment. This consent is for Chiropractic care and procedures to be performed on me, or for the patient named below (for whom I am legally responsible), whether in my presence or absence.

Patient Name (Print)	Patient Signature	Date
Guardian/Legal Representative Name (Print)	Guardian/Legal Representative Signature	Date

ChiropracticPlace
Family Wellness Centers

INFORMED CONSENT: CHIROPRACTIC CARE & ADJUSTMENTS

I hereby request and consent to receiving Chiropractic Manipulations (Adjustments) and other Chiropractic procedures, including various Physical Therapy Modalities, Exercise Therapies and any other Supportive Therapies as deemed appropriate by the Doctors of Chiropractic and performed by the Doctors of Chiropractic or Licensed Support Staff employed by, associated with, or serving as back-up support for, Chiropractic Place now or in the future.

I understand and am informed that with Chiropractic care, as in the practice of medicine and all other health care modalities, results are not guaranteed and there is no promise of a cure. I further understand and am informed that, while Chiropractic care is remarkably safe and effective and provides many patients with benefits including pain relief and enhanced health, there can be associated risks, just as in the practice of medicine. Potential risks include, but are not limited to: soreness, fractures, disc injuries, rib injury, physiotherapy burns, soft tissue injury, stroke, dislocations and sprains. With that understanding, I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment, which is in my best interest, during the course of the procedure the doctor has deemed appropriate at that time based upon the facts then known.

I also understand that there are treatment options available for my condition other than Chiropractic procedures. These treatment options include, but are not limited to: rest; self-administered care; over-the-counter analgesics; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and pain killers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I acknowledge that the Doctor of Chiropractic has discussed with me the following items:

- Explanation of my current condition;
- Proposed Chiropractic procedures;
- Risks of not receiving or undergoing any treatments or procedures.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content. I intend this consent to cover the entire course of treatment for my current condition and for any future condition(s) for which I seek treatment. This consent is for Chiropractic care and procedures to be performed on me, or for the patient named below (for whom I am legally responsible), whether in my presence or absence.

Patient Name (Print)	Patient Signature	Date
Guardian/Legal Representative Name (Print)	Guardian/Legal Representative Signature	Date

WELCOME

Welcome to Chiropractic Place! We appreciate your trust in selecting us for your health care needs. Chiropractic Place (CP) strives to provide the best care for all of our patients and seeks to have our patients actively involved in their care and rehabilitation as much as possible. Our clinics offer a variety of Chiropractic treatments, exercises, therapies and modalities to best meet your needs. Chiropractic care is for the whole family. We care for individuals of all ages and welcome referrals.

OFFICE POLICIES

Firearms: Firearms are not allowed on the premises of any CP clinic or office.

Changes/Updates: Patients are responsible for promptly notifying clinic of any changes in their insurance coverage, contact information, legal guardianship, or other pertinent data that may affect their billing or care.

Appointments: It is important that patients follow the recommended plan of treatment to maximize their healing and recovery time. If you need to reschedule an appointment, it is appreciated if you can contact our office within 24 hours prior to the appointment. Our clinics also will do our best to accommodate walk-in appointments or same-day appointment requests.

Email Reminders: CP offers Email appointment reminders as an option to patients.

> ***Note: Time sensitive issues such as medical emergencies should not be communicated via email because hours may pass between when a message is sent and when it is received and acted upon. Sensitive and highly confidential subjects should not be discussed because of the potential for the messages to be intercepted or transmitted to unintended recipients.***

Text Reminders: CP offers Text appointment reminders as an option to patients.

> ***Note: Text messages will be sent for patient appointment reminders only. Any changes to appointment dates and/or times must be made via phone or in person. Text responses will not be received by Chiropractic Place. Standard text messaging rates may apply.***

FINANCIAL POLICIES

Payment Methods: Our clinics accept Cash, Check, Credit/Debit Cards (Mastercard/Visa/Discover/American Express).

Claims Submission: As a courtesy, CP will submit claims to your primary insurance and, if applicable, your secondary insurance on your behalf. This includes Medicare and Medicaid. Please submit a copy of all insurance cards upon arrival.

Insurance Verification: As a courtesy, CP will call to verify benefits and eligibility; however, CP is not responsible for any erroneous data provided to us by your insurance carrier. CP does not guarantee that your insurance will pay. Patients are responsible for understanding their health care policy benefits and limitations. If for some reason your insurance claim is denied, you are responsible for the full amount of the bill. If you have any questions regarding your eligibility or benefit coverage, please contact your insurance carrier to discuss your policy.

Deductibles, Copays, Coinsurance, Non-Covered: Payment of Deductibles, Copays, Coinsurance and Non-Covered items are due at the time of service. Please be prepared to pay upon appointment check-in.

Cash Discount: Payment must be received at the time of service for the "Same Day Discount" to apply.

Work Comp: If a Worker's Compensation carrier does not accept liability, the patient will be financially responsible for all services.

Personal Injury & Auto: Charges will be submitted to the applicable insurance company (auto, health, liability, responsible party's insurance). Denied services will be the patient's responsibility.

Minor Patients: The legal guardian accompanying a minor is responsible to authorize treatment and provide payment for services. Billing statements will be sent to the legal custodian.

Medicare: Please note that Medicare does not pay for all of your health care costs; however, even though Medicare may not pay for a service, it does not mean you should not receive that service. Medicare Part B recognizes payment for the following Chiropractic services only: Spinal Manipulation (a/k/a Chiropractic Adjustment).

A calendar-year deductible is required for all Medicare patients. After your deductible has been met, Medicare pays 80% of the approved Spinal Manipulation. The patient is responsible for the remaining 20% Co-insurance.

Items not covered and the patient's full financial responsibility are: Exams, X-rays, Extremity Adjustments, Therapies, Nutritional Supplements, DME's/Supports, Exercise Programs, and Maintenance Care. Please note that it is our policy to obtain X-rays and perform periodic Exams as part of our treatment protocol, even though they are Non-Covered services and the patient's financial responsibility. Patients will have an opportunity to decide if they would still like receive the service(s) if not covered by Medicare via the use of an Advanced Beneficiary Notice (ABN) form.

Medicare Supplemental Plan: Medicare supplemental policies are designed to coordinate with Medicare and are plan-specific. Larger co-payments and additional benefits may apply. Some supplemental plans may pay for the Deductible and Co-insurance depending upon patient's policy. Please provide a copy of the Medicare supplemental insurance card at the same time the Medicare card is provided.

Medicaid: Please note that Medicaid covered services may vary by state. Medicaid recognizes payment for the following Chiropractic services only: Spinal Manipulations (a/k/a Chiropractic Adjustment) and X-rays when performed in conjunction with an Exam. (Please note that it is our policy to obtain X-rays and perform periodic Exams as part of our treatment protocol, even though they are Non-Covered services and the patient's financial responsibility.) Proof of insurance eligibility is required each month. Co-payments must be paid on the same day the service is provided. Non-Covered services are the patient's financial responsibility and due at time of service. Patients will have the opportunity to decide if they would still like to receive the service(s) if not covered by Medicaid.

Supplements / Durable Medical Equipment (DME):
Payment for these items is due at the time of purchase.

Returns / Exchanges / Refunds:
We do not accept returns or exchanges for opened or used items (supplements, DME's, therapy items, etc.), unless under manufacturer's warranty. Other items may be returned to the clinic of original purchase unopened and unused within 15 days of purchase for a refund or exchange.

ACCOUNT QUESTIONS

CONSENTS & AUTHORIZATIONS

- **Notice of Privacy Practices** - I acknowledge that I have received the Notice of Privacy Practices and have separately signed the "Acknowledgement of Receipt of the Notice of Privacy Practices."

- **Authorization for Use & Disclosure of Protected Health Information (PHI) and Wisconsin & Minnesota Consent** – I understand that by signing below I authorize the Use and Disclosure of my Protected Health Information (PHI) described herein and in the Notice of Privacy Practices that has been provided to me. I also acknowledge that CP has reserved the right to make changes to the privacy practices as necessary. If CP makes any changes, a revised Notice of Privacy Practices will be provided to me. I understand those changes will apply to any of my PHI that CP maintains.

  Check any additional Use and Disclosure authorizations that may apply:

  ☐ I consent to disclosure of my patient health care records for disaster relief purposes as permitted by law.

  ☐ I consent to use and disclosure of my patient health care records to the following person(s), including those involved in my care or payment for that care. [Specify person(s) below]:

  _____ _____
  (Person Name) (Relationship)

  _____
  (Address)

  _____ _____
  (Person Name) (Relationship)

  _____
  (Address)

  Unless indicated by me otherwise, CP may use professional judgment and experience with common practice to make reasonable inferences of my best interest in allowing a person acting on my behalf to pick up supplies, X-rays or other similar forms of PHI as applicable.

  Copy of Consent – I understand I am entitled to a copy of this Consent and Policy Brochure and I will inform clinic staff if I choose to have a copy. The original will be retained in my patient file.

Effect of Declining Consent –I understand that this consent is a condition of my treatment with AHCC and if I decide not to sign this consent, treatment may be declined.

Right to Revoke – I understand this consent is in effect until I choose to revoke it and I have the right to revoke it at any time by giving written notice. I acknowledge that such revocation will not affect any action CP took in reliance on this consent before receiving the revocation. I also understand that upon revocation, CP may decline to continue treatment.

- **Release of Information** - I authorize the release of any information pertinent to my case to any insurance company, adjustor or attorney involved in my case.
- **Assignment of Direct Payment** - I authorize any and all benefit payments to be made on my behalf directly to CP.
- **Financial Policies** - I understand and agree to adhere to the Financial Policies as outlined above and described herein.
- **Office Policies** – I understand and agree to adhere to the Office Policies as outlined above and described herein.
- **Email or Text Reminders** – I understand the policies outlined above and described herein and authorize Email or Text appointment reminders to be sent to me. I further understand that I can unsubscribe from email communications or discontinue text reminders at any time by providing written notice. I understand that this is an optional service and is provided as a courtesy only.

☐ I am NOT interested in receiving Email or Text messages for appointment reminders.

-OR- Select one (optional):

☐ Email Address: _____

☐ Cell Phone #:_____

Carrier Name_____

- **Diagnostic Procedures, Xrays & Examinations**
I hereby request and consent to receiving Diagnostic Procedures, including X-rays, and Chiropractic Examinations from the Doctors of Chiropractic and/or licensed support staff employed by, associated with, or serving as back-up support for CP.

This consent is for these procedures to be performed on me, or for the patient named herein (for whom I am legally responsible), whether in my presence or absence.

PATIENT SIGNATURE

By affixing my signature below, I acknowledge that I have fully read and understand the items listed above. I hereby consent, authorize and acknowledge the policies, consents and items as listed above and described herein and as outlined within the Notice of Privacy Practices provided by Chiropractic Place:

_____

Patient Name (Print)

_____ _____

Patient Signature Date

_____ _____

Legal Guardian/Representative Name (Print) Relationship

_____ _____

Legal Guardian/Representative Signature Date

ChiropracticPlace
Family Wellness Centers

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,_____, have received a copy of this office's Notice of Privacy Practiced. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment.
- Obtain payment from third-party payors.
- Conduct normal healthcare operations such as quality assessments and accreditation.

_____

{Please Print Name}

_____

{Signature}

_____

{Date}

_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)_____

Staff Signature _____ Date _____