Insurance

For office use only:
Ins Checked ☐
TY sent ☐
Date entered in CT: _____
CA initials _____

Great Day
Chiropractic & Rehab

Are you in the right place?
Please read this before proceeding with paperwork:

At **Great Day Chiropractic & Rehab**, we specialize in treating **neuro-musculo-skeletal** (nerve, muscle, bone) conditions from a chiropractic perspective. In other words, we mobilize injured joints that have become fixated or "stuck" due to sudden injury or long-term stresses. There are about 40 conditions that respond well to chiropractic treatment so, with that in mind, the first thing we will do is determine if your problem is indeed **neuro-musculo-skeletal** in nature and if you are a good fit for our care. If you're not a candidate for chiropractic care, we will refer you to a physician or specialist better suited for your condition. Keep in mind that underlying medical problems may exist, and you should always make your primary care provider aware of any symptoms that you are experiencing.

Typically, there is a sequence of events that brings a patient like you into our office. These events can unfold over a period of days or a period of years:

- Your body is subjected to injury, repetitive motion, and/or chronic tension causing pain.
- Your body reacts with muscle tightness, spasms, and inflammation.
- Scar tissue is created, causing your muscles to stiffen and stick together.
- You begin to lose range of motion and feel pain, weakness, and other symptoms.
- Other muscles compensate, and this over-stresses them.
- The body begins to “learn” that all of this dysfunction is normal.

Your symptoms are likely part of a cycle of injury, physical stress, and muscular dysfunction. To decrease pain and restore your body and joints to a full, free, and painless state we will use the following methods and techniques where appropriate in 3 distinct phases of care:

Phase 1: Relief Care – Our goals are to get you out of pain, to stop your condition from worsening and begin to reverse it.

- Chiropractic manipulation or "adjustments" to increase range of motion and break up joint adhesions (joints that are “stuck”).
- Electrical muscle stimulation (e-stim) and/or ultrasound therapy to increase blood flow, decrease muscle spasm and inflammation.
- Ice and/or moist heat to increase blood flow, decrease muscle spasm and inflammation.
- Active stretching to increase range of motion and relax the muscles. To be done at home and in our office.
- Nutritional support - a recommendation of dietary changes and nutritional supplements to aid your body in recovery.

Phase 2: Stabilization Care – Our goal is to shift from short-term pain relief to long-term prevention.

- Decrease in the number of office visits.
- Decrease home stretching.
- Begin strengthening exercises to retrain your body in normal movement patterns and to “unlearn” dysfunctional patterns. This helps your muscles to “remember” that full, free, painless motion is normal again. This can also correct poor posture.
- Increase your strength and flexibility. This will prepare your body to better handle whatever stresses you subject it to. (sports, work, etc..).
- Teach you how to prevent the problem from returning.

Phase 3: Wellness Care – Optional

- Some patients return on an “as need” or on a more regular basis to maintain their restored health. This is completely up to each individual.

On average, between 6-12 treatments visits may be required to correct your problem. More serious issues, such as automobile accident injuries, can require additional visits. If your condition does not begin to improve after 4-6 visits, a second opinion from a medical provider or other specialist is appropriate. Also, should your symptoms return after successful treatment, you should contact your primary care provider. We strongly encourage you to see your medical provider regularly. Soreness may be a side effect of your treatment. Please report any worsening of your symptoms to us immediately. Chiropractic adjustments to carry a small risk of injury. If you have any questions about this risk, please feel free to ask.

_____	_____	_____
SIGNATURE	**PRINTED NAME**	**DATE**

8016 State Line Rd., Ste. 100
Prairie Village, KC 66208
P: 913-341-4300
F: 913-341-4301
www.ChiropracticKansas.com

CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential, We comply with all federal privacy standards.
Please print clearly.

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?
☐ No ☐ Yes **When?**

Whom may we thank for referring you?

If so, whom?

Your Last Name

Gender
☐ Male ☐ Female

How would you like to be addressed?

Your First Name | Your Middle Name (or Initial) | Birth Date (MM/DD/YYYY) | Your Age

Address

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

City | State | Zip/Postal Code | Home Phone | Spouse's Name

Email Address | Cell Phone | Child's Name and Age

Emergency Contact | Phone | Child's Name and Age

Your Occupation | Child's Name and Age

Your Employer

May we contact you at work?
☐ No ☐ Yes

Address

City | State | Zip/Postal Code | Work Phone

Insurance Carrier | Policy Number | Primary Care Provider's Name

Insured's Last Name | Insured's Social Security Number

Insured's First Name | Middle Name (or Initial)

Who carries this policy?
☐ Self ☐ Spouse ☐ Divorced

Insured's Phone Number | Insured's Date of Birth

Insured's Address

City | State | Zip/Postal Code | Employer's Phone

CONFIDENTIAL HEALTH INFORMATION

1. The symptom(s) that have prompted me to seek care today include:_____

_____

2. And are the result of (check box) ☐ An accident or injury
☐ Work ☐ Auto ☐ Other _____
☐ A worsening long-term problem_____
☐ An interest in: ☐ Wellness ☐ Other _____

3. Onset (When did you first notice your current symptoms?)

_____

4. Intensity (How extreme are your current symptoms?)

0 ○○○○○○○○○○ 10
Absent Uncomfortable Agonizing

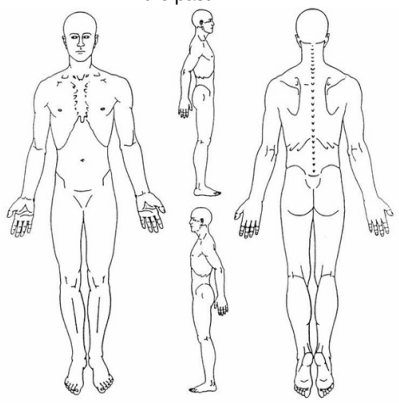
5. Duration and Timing (What % of the time do you feel symptoms?)

○○○○○○○○○○
0% 50% 100%

6. Quality of symptoms (What does it feel like?)

☐ Numbness
☐ Tingling
☐ Stiffness
☐ Dull
☐ Aching
☐ Cramps
☐ Nagging
☐ Sharp
☐ Burning
☐ Shooting
☐ Throbbing
☐ Stabbing
☐ Other _____

7. Location (where does it hurt?)
Circle the area(s) on the illustration.
"O" for current condition
"X" for conditions experienced in the past.



8. Radiation (does it affect other areas of your body? To what areas does the pain radiate, shoot, or travel)

_____

9. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)
What tends to **worsen** the problem?_____
What tends to **lessen** the problem?_____

10. Prior Interventions (What have you done to relieve the symptoms?)

☐ Prescription Medication ☐ Surgery ☐ Ice
☐ Over-the-counter drugs ☐ Acupuncture ☐ Heat
☐ Homeopathic remedies ☐ Chiropractic
☐ Physical Therapy ☐ Massage
Other _____
_____

11. What else should we know about your current condition?_____

12. How does your current condition interfere with your:

Work or career: _____

Recreational activities:_____

Household responsibilities: _____

Personal relationships: _____

13. Review of Systems
Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please mark the square beside any condition that you **Had** or currently **Have** and initial to the right.

a. Musculoskeletal

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	
☐ ☐ Osteoporosis	☐ ☐ Arthritis	☐ ☐ Scoliosis	☐ ☐ Neck pain	☐ ☐ Back problems	☐ ☐ Hip disorders	**None** ☐
☐ ☐ Knee Injuries	☐ ☐ Foot/Ankle pain	☐ ☐ Shoulder problems	☐ ☐ Elbow/wrist pain	☐ ☐ TMJ issues	☐ ☐ Poor posture	Initials___

b. Neurological

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	
☐ ☐ Anxiety	☐ ☐ Depression	☐ ☐ Headache	☐ ☐ Dizziness	☐ ☐ Pins and needles	☐ ☐ Numbness	**None** ☐ Initials___

b. Cardiovascular

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	
☐ ☐ High blood pressure	☐ ☐ Low blood pressure	☐ ☐ High Cholesterol	☐ ☐ Poor circulation	☐ ☐ Angina	☐ ☐ Excessive bruising	**None** ☐ Initials___

b. Respiratory

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	
☐ ☐ Asthma	☐ ☐ Apnea	☐ ☐ Emphysema	☐ ☐ Hay fever	☐ ☐ Shortness of breath	☐ ☐ Pneumonia	**None** ☐ Initials___

b. Digestive

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	
☐ ☐ Anorexia/bulimia	☐ ☐ Ulcer	☐ ☐ Food sensitivities	☐ ☐ Heartburn	☐ ☐ Constipation	☐ ☐ Diarrhea	**None** ☐ Initials___

b. Sensory

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	
☐ ☐ Blurred vision	☐ ☐ Ringing in ears	☐ ☐ Hearing loss	☐ ☐ Chronic ear infection	☐ ☐ Loss of smell	☐ ☐ Loss of taste	**None** ☐ Initials___

_____
Patient name

☐ All other systems negative

[Consultation Notes]

_____
Doctor's initials

a. Integumentary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		None ☐
☐	☐	Skin cancer	☐	☐	Psoriasis	☐	☐	Eczema	☐	☐	Acne	☐	☐	Hair loss	☐	☐	Rash	Initials___

b. Endocrine

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		None ☐
☐	☐	Thyroid issues	☐	☐	Immune disorders	☐	☐	Hypoglycemia	☐	☐	Frequent infection	☐	☐	Swollen glands	☐	☐	Low energy	Initials___

b. Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		None ☐
☐	☐	Kidney stones	☐	☐	Infertility	☐	☐	bedwetting	☐	☐	Prostate issues	☐	☐	Erectile dysfunction	☐	☐	PMS symptoms	Initials___

b. Constitutional

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		None ☐
☐	☐	Fainting	☐	☐	Low libido	☐	☐	Poor appetite	☐	☐	Fatigue	☐	☐	Sudden weight change	☐	☐	Weakness	Initials___

Patient name

☐ All other systems negative

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

14. Illnesses

Check the illnesses you have Had in the past or Have now. (Please check all that apply)

Have	Had		Have	Had	
☐	☐	AIDS	☐	☐	Tuberculosis
☐	☐	Alcoholism	☐	☐	Typhoid fever
☐	☐	Allergies	☐	☐	Ulcer
☐	☐	Arteriosclerosis	☐	☐	Other
☐	☐	Cancer			
☐	☐	Chickenpox			
☐	☐	Diabetes			
☐	☐	Epilepsy			
☐	☐	Glaucoma			
☐	☐	Goiter			
☐	☐	Gout			
☐	☐	Heart disease			
☐	☐	Hepatitis			
☐	☐	Malaria			
☐	☐	Measles			
☐	☐	Multiple Sclerosis			
☐	☐	Mumps			
☐	☐	Polio			
☐	☐	Rheumatic fever			
☐	☐	Scarlet fever			
☐	☐	Sexually transmitted disease			
☐	☐	Stroke			

15. Operations

Surgical interventions, which may or may not have included hospitalization.

☐ Appendix removal
☐ Bypass surgery
☐ Cancer
☐ Cosmetic surgery
☐ Elective surgery_____
_____
_____

☐ Eye surgery
☐ Hysterectomy
☐ Pacemaker
☐ Spine_____
_____
_____

☐ Tonsillectomy
☐ Vasectomy
☐ Other_____
_____

16. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

☐ ☐ Acupuncture
☐ ☐ Antibiotics
☐ ☐ Birth control pills
☐ ☐ Blood transfusions
☐ ☐ Chemotherapy
☐ ☐ Chiropractic care
☐ ☐ Dialysis
☐ ☐ Herbs
☐ ☐ Homeopathy
☐ ☐ Hormone replacement
☐ ☐ Inhaler
☐ ☐ Massage therapy
☐ ☐ Physical therapy
☐ ☐ Nutritional supplements
List:_____
_____
_____

☐ ☐ Medications (prescription and over-the-counter)
_____
_____
_____

17. Injuries – Have you ever...

☐ Had a fractured or broken bone
☐ Had a spine or nerve disorder
☐ Been knocked unconscious
☐ Been injured in an accident
☐ Used a crutch or other support
☐ Used neck or back bracing
☐ Received a tattoo
☐ Had a body piercing

[Consultation Notes]

Family History

Some health issues are hereditary. Tell us about the health of your immediate family members.

FAMILY

Relative	Age (If living)	State of health Good	Poor	Illnesses	Age at death	Cause of death Natural	Illness
Mother	_____	☐	☐	_____	_____	☐	☐
Father	_____	☐	☐	_____	_____	☐	☐
Sister 1	_____	☐	☐	_____	_____	☐	☐
Sister 2	_____	☐	☐	_____	_____	☐	☐
Brother 1	_____	☐	☐	_____	_____	☐	☐
Brother 2	_____	☐	☐	_____	_____	☐	☐
_____	_____	☐	☐	_____	_____	☐	☐

19. Are there any other hereditary health issues that you know about? _____
_____

Doctor's initials

20. Social History

Tell us vour health habits and stress levels.

SOCIAL

Alcohol use	☐ Daily ☐ Weekly	How much?_____	Prayer or mediation?	Yes ☐	No ☐
Coffee use	☐ Daily ☐ Weekly	How much?_____	Job pressure/stress?	Yes ☐	No ☐
Tobacco use	☐ Daily ☐ Weekly	How much?_____	Financial peace?	Yes ☐	No ☐
Exercising	☐ Daily ☐ Weekly	How much?_____	Vaccinated?	Yes ☐	No ☐
Pain relievers	☐ Daily ☐ Weekly	How much?_____	Mercury fillings	Yes ☐	No ☐
Soft drinks	☐ Daily ☐ Weekly	How much?_____	Recreational drugs?	Yes ☐	No ☐
Water intake	☐ Daily ☐ Weekly	How muc?_____			

Hobbies _____

21. Activities of Daily Living
How does this condition currently interfere with your life and ability to function? (for each activity, circle the number that most closely describes your condition right now)

	No Affect	Mild Affect	Moderate Affect	Severe Affect	Worst Possible Pain		No Affect	Mild Affect	Moderate Affect	Severe Affect	Worst Possible Pain
Pain Intensity	0	1	2	3	4	Recreation	0	1	2	3	4
Sleeping	0	1	2	3	4	Frequency of pain	0	1	2	3	4
Personal Care (washing, dressing etc)	0	1	2	3	4	Lifting objects	0	1	2	3	4
Travel (driving, etc.)	0	1	2	3	4	Walking	0	1	2	3	4
Work	0	1	2	3	4	Standing	0	1	2	3	4

Score _____

22. What is the major stressor in your life?_____23. How much do you sleep on average per night?_____Hours

24. What is the type and approximate age of your mattress and pillow?_____

25. What is your preferred sleeping position?_____

26. Describe your typical eating habits ☐ Skip breakfast ☐ Two meals a day ☐ Three meals a day ☐ Snacking between meals

27. What would be the most significant thing that you could do to improve your health? _____

_____

_____

28. In addition to the main reason for your visit today, what additional health goals do you have? _____

Acknowledgments
To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement to the following:

Initials ____ I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials ____ I realize that an x-ray examination may be hazardous to an unborn child and I certify to the best of my knowledge I am not pregnant. Date of last menstrual period. _____

Initials ____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, e-mails or health information to me as an extension of my care in this office.

Initials ____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initials ____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

If the patient is a minor child, print the child's full name: _____

_____ Signature

_____ Date (MM/DD/YYYY)

_____ Patient name

☐ All other systems negative

[Consultation Notes]

_____ Doctor's initials

FINANCIAL POLICY

At **Great Day Chiropractic & Rehab**, we understand that the cost of healthcare is a key concern for our patients. Although patient care is our main priority, we hope that you will assist us by understanding your responsibility as it relates to our Financial Policy. If you have any questions regarding our policy a member of our staff will be glad to assist you.

HEALTH INSURANCE

- As a courtesy to you, when given a copy of your insurance card, we will call and find out your benefits for chiropractic care in our office.
- We do not file claims for **acupuncture, massage, lab work, orthotics, supplements or merchandise** to your insurance.
- If you receive care that we do not file for, you will need to pay for the services rendered. If you would like to submit the charges yourself for reimbursement, we will be happy to make copy of your fee slip. Please remember-the benefits information your insurance company quotes us is not a guarantee of payment from them and any remaining fees are due immediately from you.

MEDICARE

- Medicare covers spinal adjustments only. After your yearly deductible has been met, Medicare should cover 80% of the allowed costs for adjustments. You will be responsible for the remaining 20%, as well as the cost for any non-covered services.
- You will be asked to fill out an advanced beneficiary notice for non-covered services.

SECONDARY INSURANCE

- Please inform us of any secondary insurance you may have. We will be glad to file chiropractic claims to your secondary insurance after your primary insurance has processed the claim(s).

AUTO ACCIDENTS AND MED-PAY

- If you've not already done so, please notify your auto insurance carrier of your accident immediately. We will have you fill out the proper document so we can file claims with your insurance carrier. We will call your adjuster together the information we need to file.
- If you reach the maximum amount payable under your auto insurance, we will file the claim that your health insurance. Although you are ultimately responsible for your Bill, we will do whatever we can to secure reimbursement from your insurance carrier. Once the claim is settled or if you suspend/terminate care against physicians recommendations, any remaining fees are due immediately from you.
- If there is a third party involved (such as an attorney), you'll be asked to make partial payments as care is received. Accepting assignment and/or liens is done so under a pre-qualified understanding between the patient, this office and the third party payor(s). Establishing an honest ethical working relationship allows this office to continue accepting liens and assisting patients in their goals for better health. Any and all changes of the original party's agreement, independent of this office's knowledge or consideration, immediately disqualifies the terms of that agreement and demands immediate payment on the outstanding balance.

PATIENTS WITHOUT INSURANCE

- We request that 100% of all visits be paid at the time of service.
- We gladly accept cash, checks, credit cards, HSA, and flex-pay cards.
- Our office has established a single-fee schedule that applies to all patients for each service provided based allowable limits determined to be reasonable and customary for the state of Colorado. We cannot offer "cash" or time of service discounts greater than 10% below these rates, however, we do offer discounts for members of discount groups such as ChiroHealthUSA. Discount members are entitled to discounts similar to insured patients. Membership is $49.00 per year and covers you and your dependents. Ask a staff member for details if you are interested.

Changes to any appointment should be made 24 hours in advance to avoid a $25 service fee. Reschedules should be confirmed and done directly with the front desk. The Doctor is the only one qualified to change your treatment schedule.

When you pay by check you expressly authorize this office, if your check is dishonored or returned for any reason, to electronically debit your account for the amount of the check, plus a processing fee of $25 and any applicable sales tax. The use of a check for payment is your acknowledgment and acceptance of this policy and it's terms.

Financial arrangements are valid under your present condition. They are subject to renewal by the start of each New Year. Should changes arise in your medical or financial situation that would affect your current financial agreement, you must notify this office prior to your care. Should you discontinue care or be released from further service, at this office, all outstanding balances are due upon notification.

Any past due balance not paid **within 90 days** will be reported to the credit bureau and turned over to an attorney, small claims court, or agency for collections. You will be responsible for all charges related to this collection process. Please keep your account current to avoid any action or blemish on your credit history.

Thank you for your understanding of our Financial Policy. Please let us know if you have any questions.

I have read, understand and agree to this Financial Policy in its entirety.

Printed Name:_____

Signature: _____ Date: _____

PATIENT PRIVACY

This practice is committed to maintaining the privacy of your protected health information (PHI), which includes information about your health condition and the care you receive from the practice. This notice details how this information may be used in this office. With consent from you, it is the policy of this office to use the your PHI in the following manners:

1. Treatment: Your PHI will be given to those professionals that require it to provide care.
2. Appointment reminders: Our staff may call from time to time to remind you of appointments
3. Sign-in Log: We maintain a log of incoming patients for our own statistical use
4. Referral board: We keep a board to thank member of our practice who have referred others
5. Medical Doctors: It is the policy of this office to share our findings with your regular medical doctor. This helps build a better understanding of how we may work together to improve your health.

In special circumstances, your PHI may be disclosed as in the following:

1. Personal Representative: In accordance with applicable law that may represent you.
2. Emergency situations
3. Abuse, Neglect, or Domestic Violence
4. Law Enforcement issues
5. Worker's Compensation claim
6. Avert a health threat

Your rights regarding your health information:

1. Right to inspect and copy your records: A written request must be submitted and cost of copying may be applied to such a request
2. Amend your PHI by submitting a written request with an explicit reason.
3. Request restrictions on your PHI. However, this practice is not obligated to agree to any such restrictions.
4. Revoke consent at any time
5. Complain to the practice

Printed Name:_____

Signature: _____ Date: _____

CONSENT TO TREAT

The primary treatment used by doctors of chiropractic is the spinal adjustment.
We will use that procedure to treat you.

• The nature of the chiropractic adjustment.
We will use hands or a mechanical device upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel or sense movement.

• The material risks inherent in chiropractic adjustment.
As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include: fractures, disc injuries, dislocations, and muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

• The probability of those risks occurring.
Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and x-ray. Stroke has been the subject if tremendous disagreement within and without the profession with one prominent authority1 saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare."

• The availability and nature of other treatment options.
Other treatment options for your condition include:
• Self-administered, over-the-counter analgesics and rest
• Medical care with prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
• Hospitalization with traction
• Surgery

The material risks inherent in such options and the probability of such risks occurring include:

• Overuse of over-the-counter medications produces undesirable side-effects. If complete rest is impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his pain tolerance and self-discipline in not abusing the medicine. Professional literature describes highly undesirable effects from long term use of over-the-counter medicines.
• Prescription muscle relaxants and pain-killers can produce undesirable side effects and patient dependence. The risk of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his pain tolerance, self-discipline in not abusing the medicine and proper professional supervision. Such medications generally entail very significant risks — some with rather high probabilities. • Hospitalization in conjunction with other care bears the additional risk of exposure to communicable disease, iatrogenic (doctor induced) mishap and expense. The probability if iatrogenic mishap is remote, expense is certain, exposure to communicable disease is likely with adverse result from such exposure dependent upon variables.
1 Haldeman, Scott, D.C. M.D.
• The risks inherent in surgery include adverse reaction to anesthesia, iatrogenic (doctor caused) mishap, all those of hospitalization and an extended convalescent period. The probability of those risks occurring varies to many factors.

• The risks and dangers attendant to remaining untreated.
Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

Do Not Sign Until You Have Read And Understand The Above.

Please Check The Appropriate Block and Sign Below:

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with my Doctor of Chiropractic and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.
Dated: _____ _____
Printed Name

_____
Signature

Witnesses: _____
Signature of Parent or Guardian (if a minor)

_____
Printed Name

_____
Signature