Backcare Plus Chiropractic – 2018 Patient Information
Please provide us with your full LEGAL name, and print information neatly.

Name: _____
Last First Middle

Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____ Marital Status: _____

DOB: ____/_____/_____ Age: _____ SSN: _____-_____-_____

*If under 18yr, parental contact info: _____
Occupation: _____Employer:_____
Name of Spouse: _____
Emergency Contact Name & Phone: _____
Previous Chiropractic Care? _____ If so, where? _____
Referred by:_____ Primary Care Physician:_____

PRIMARY INSURANCE
Company:_____
Member ID:_____
Group number:_____
Primary Insured:_____

SECONDARY INSURANCE
Company:_____
Member ID:_____
Group number:_____
Primary Insured:_____

**Please list the name(s) of everyone you authorize us to discuss your account/care with (other than insurance):
_____

- **If you have Medicare and a secondary insurance, you are responsible for notifying Medicare about the secondary coverage. We DO NOT file secondary insurance, because Medicare forwards your claims automatically.**
- **WE ONLY BILL PRIMARY INSURANCE. You are responsible for filing your secondary and submitting payment to us in the event that payment is made directly to you.**
- **I understand and agree that I will be responsible for any balance not covered by insurance.**
- **I understand that there is a $35 fee for returned checks.**

I have completed this form accurately, truthfully, and completely. I certify that I am the patient or authorized guardian. If mine is regular health insurance case, I agree to pay a percentage of services or my co-pay at the time services are rendered. However, I understand that I am ultimately responsible for payment in full to this office should insurance be denied. If I suspend or terminate my care prematurely, any fees remaining will be immediately due to this office. I also understand and agree that health and accident insurance policies are an arrangement between the company and me - not this office. I authorize this office to release any medical information and to complete any usual reports/forms at no charge, in order to assist in collecting monies from my insurance company.

_____ _____
Patient Signature (guardian if under 18) Date

_____ _____
Witness Date

** This authorization will expire at midnight on December 31, 2018. **

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop" and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound, traction or cold laser may also be used.
Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritations or minor complications.
Probability of risks occurring: The risks of complications due to chiropractic treatment are rare. The risk of cerebrovascular injury, or stroke, has been estimated at one in one million to one in twenty million. The probability of adverse reaction due to ancillary procedures is also considered rare.
Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics*. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care*, typically anti-inflammatory drugs, tranquilizers and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number or cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles.
It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and herby give my full consent to treatment.

Patient/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

X-Ray Waiver

This waiver warrants that I have been advised by Backcare Plus Chiropractic that x-rays are recommended to be taken to facilitate thorough analysis and research of my present condition. I hereby authorize Backcare Plus Chiropractic to treat my present problem/condition to the best of their ability without the use of x-rays. Therefore, should any further illness or adverse injury develop as a result of such treatment, I shall assume all responsibility for being treated at my request without the benefit of x-ray analysis. I hereby release Backcare Plus Chiropractic from all damages, liabilities, adverse effects or injury arising from said treatments, whether such injury existed before or appears from this moment forward and whether now known or unknown by all parties involved.

_____ Yes, I consent to have x-rays taken _____ No, I do not wish to have x-rays taken

Patient/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

BACK care plus
Chiropractic, P.C.

Signature On File

* I understand that verification of my insurance benefits is not a guarantee of payment.

*I understand that I am responsible for the portion of my bill that insurance does not cover.

*I authorize the use of this form on all of my insurance submissions.

*I understand that if I cancel my massage appointment without 24 hours notice, I may be charged a $30 fee.

*I authorize release of my information to all of my insurance companies.

*I authorize my doctor's office to act as my agent in helping me obtain payment from my insurance companies.

*I authorize direct payment to my doctor from my insurance companies.

*I understand that Backcare Plus files my insurance as a courtesy.

*I understand that the Doctor is not responsible for arising problems if I am not compliant with all instructions and recommended care plans and/or treatments.

*I understand that all my records are kept confidential, with the exception of those necessary for collection or insurance billing purposes. I also permit a copy of this authorization to be used in place of the original.

Please sign to show that you have read and understand the statements above.

Signature: _____ Date_____

Witness: _____ Date: _____