# Patient Introduction Card

Date: _____ Ethnicity: _____

Name_____ Patient S.S. # _____

Address_____ Date of Birth _____

City _____, State_____ Zip_____ Occupation_____

E-mail Address: _____ Employer_____

Phone (Cell) _____ Address_____

Phone (Home) _____ _____

Sex: M/F Status: Single/ Married/ Divorced/ Wid Work Phone_____

Referred to this office by: _____, Primary Care Physician: _____

I may be informed by Dr. Chris Oliver that diagnostic x-rays are advisable in my case so that a complete analysis can be made of my present musculoskeletal problem or illness. I authorize Dr. Oliver to perform such radiographic examinations as necessary to diagnose and to administer whatever treatment is deemed necessary to treat my present problem or illness.
**Patient's Signature**: _____
PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorized the release of any medical or other information necessary to process this claim. I also request payment of government benefits to the party who accepts assignment below.
**Patient's Signature**: _____
INSURED'S OR AUTHORIZED SIGNATURE. I authorized payment of medical benefits to Dr. Chris Oliver of Complete Health Chiropractic and Acupuncture/ Oliver Chiropractic and Acupuncture for services performed.
**Patient's Signature**: _____
I have been advised regardless of what my insurance covers that acupuncture will not be billed to my insurance. I will be responsible to pay for each treatment at a flat rate of $65.00 per treatment. **Patient's Signature**: _____
I understand and agree that, regardless of my insurance, I am responsible for the balance on my account for the professional services rendered. I also understand that if at any time default occurs on my account I will be not only responsible for the total balance due but also any reasonable attorney fees, address searches as well as a 5% per month interest rate. I certify the information I have provided in this packet is true and correct to the best of my knowledge. I will notify you of any changes in my health status. **Patient Signature**: _____
The best of my knowledge, I am NOT pregnant, and Dr. Oliver has my permission to x-ray me.
**Patient's Signature**: _____

## Informed Consent

You have the right to be informed about your condition and the possible options for treatment. This includes knowing the risks and benefits related to each treatment option. This information will help you make an informed decision about whether or not to follow the recommended care. When a patient seeks our chiropractic care it is important for doctor and patient to be working towards the same goal. Chiropractors focus on finding and removing subluxations. Subluxations are misalignments of joints in the body that prevent normal movement. This can change nerve function and hinder the body's natural ability to heal. We remove these subluxations through the use of adjustments. An adjustment can be a specific thrust or relaxing the muscles, ligaments, tendons there by regaining normal spinal position and movement from fixated, misaligned joints. This allows the nervous system to work better at keeping you healthy. In addition to the many benefits of chiropractic care, there are also some risks. These risks should be considered when making the decision to receive chiropractic care. All health care procedures have some risk associated with them. Symptoms you may feel after starting care include muscle spasm, bruising, nausea, dizziness, fatigue and soreness. Severe risks such as nerve injury, fracture, and stroke are very rare but can occur. The technique used in this office is very gentle using light massaging to relax the muscle ligaments and tendons so that normal spinal position and movement may be gain on its own and greatly decreases risks. We do not use techniques that incorporate thrusting, torque, twisting, bending sometimes initiating cracking or popping noise. There is no guarantee that the treatments will provide the expected or desired outcomes. Your lifestyle, including diet, exercise and stress level, will affect your results. If, at any time, you have questions or concerns regarding your treatment please contact our office. The doctor will be happy to discuss them with you.

**Consent for Chiropractic Care:** I have read and understand the purpose of chiropractic care and the potential risks involved. I also understand that the doctor does not guarantee my response to care. Other treatment options have been explained to me and my questions about this consent form have been addressed. I HAVE READ THE ABOVE INFORMATION AND UNDERSTAND WHAT I HAVE READ. I CONFIRM THAT ALL MY QUESTIONS HAVE BEEN ANSWERED. I CONSENT TO RECEIVE THE CHIROPRACTIC CARE DEEMED NECESSARY BY THE DOCTOR ON THIS DATE.

**Parental Consent for Minor Patient**: **Patient Name: _____, DOB: _____**

**Patient Signature: _____, Doctor Signature:** Dr. C. Oliver