CONFIDENTIAL PATIENT REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date: ______________

Name: ______________________________________
Last Name First Name Initial

Address: ______________________________________

____

Home Phone #: ______________________________

Work Phone #: ______________________________

Cell Phone #: ______________________________

E-mail Address: ______________________________

Social Security #: ______________________________

Sex: ☐ M ☐ F Age: _______ Birth date: __________

Female Patients: Are you, or may you possibly be pregnant?

☐ Yes ☐ No, Start date of most recent menstrual cycle______

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Occupation: ______________________________

Employer: ______________________________

CONTACT IN CASE OF AN EMERGENCY:

Name: ________________ Relation: __________

Phone #: ______________________________

Is condition due to an accident? ☐ Yes ☐ No __________

Have you ever had Chiropractic treatment? ☐ Yes ☐ No

If Yes, How long ago? ______________________

Reason? ______________________________

How did you hear about our office? ______________

Referred By ? ______________________________

2 INSURANCE INFORMATION

Health Insurance *(Primary)*

Ins Co.: ______________ Phone: ______________

Policyholder name: ______________________________

Relationship to policyholder: ______________________

Policy #: ________________ Group#: __________

Health Insurance *(Secondary)*

Ins Co.: ______________ Phone: ______________

Policyholder name: ______________________________

Relationship to policyholder: ______________________

Policy #: ________________ Group#: __________

Complete the following if injury is related to an auto accident.

Motor Vehicle Insurance *(Your PIP Info)*

Owner of vehicle in which you were injured:

____

Ins Co.: ______________ Phone: ______________

Policy #: ______________________________

Claim #: ______________________________

Have you retained an attorney? ☐ Yes ☐ No

Name: ______________ Phone: ______________

Third Party Information *(Other vehicle that struck yours)*

Name: ______________ Phone: ______________

Ins Co.: ______________ Phone: ______________

Policy #: ______________ Claim #: ______________

3 Auto ACCIDENT INFORMATION *(IF APPLICABLE)*

Date of Injury: ________________ Time: __________ AM/PM State: ☐ SC ☐ Other ______________

Describe in DETAIL how your injury occurred: ______________________________________

____

____

Were you the: ☐ Driver ☐ Passenger Were you sitting in the: ☐ Front Seat ☐ Back Seat

Were you struck from: ☐ Behind ☐ Front ☐ Left Side ☐ Right Side Were you wearing a seatbelt? ☐ Yes ☐ No

Did you know you were going to be hit? ☐ Yes ☐ No Did you brace for impact? ☐ Yes ☐ No

Approximate speed your vehicle was traveling _________mph *OR* were you stopped? ☐ Yes ☐ No

Approximate speed the other vehicle(s) were traveling _________mph

Make & Model of your vehicle: ____________________ Make & Model of other vehicle: ____________________

Were police notified? ☐ Yes ☐ No Did the police file a report? ☐ Yes * ☐ No

**** If yes, you must provide a copy of this report to this office within 5 business days of today's date.***

What was the approximate damage to vehicle: ☐ Minimal ☐ Moderate ☐ Extensive ☐ Totaled

Amount of Damage: $________________ Was your vehicle towed from the scene? ☐ Yes ☐ No

4 Work *(or Other)* INJURY INFORMATION *(IF APPLICABLE)*

Date of Injury:____________________ Time:___________ AM/PM State: ☐ SC ☐ Other ______________________

Describe in DETAIL how your injury occurred: ____

____

____

____

____

____

____

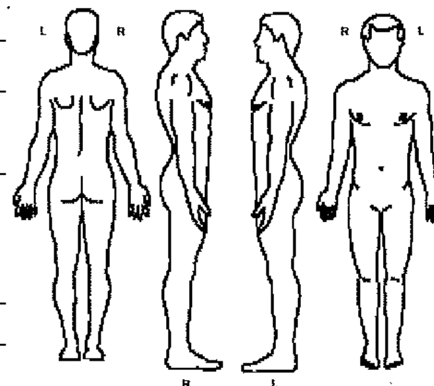
____

____

5 CURRENT COMPLAINTS

What are your present complaints? *(Location of pain, etc.)*______________________________

____



Use an "X" on the drawing to mark where you are experiencing pain *(or other symptoms)*.

When did these symptoms first appear? ________________________________

Do your symptoms interfere with: ☐ Sleep ☐ Daily routine ☐ Work ☐ Recreation

Are you working less hours / days as a result of your injuries? ☐ Yes ☐ No

If yes, please explain ____

Activities or movements that are painful to perform: ______________________

☐ Sitting ☐ Standing ☐Walking ☐ Bending ☐ Lying Down ☐ Other: ________________

Intensity of symptoms: ☐ Mild ☐ Moderate ☐ Severe   Timing: ☐ Constant ☐ Intermittent ☐ Frequent ☐ Occasional

Please rate your current symptoms (pain) on scale 0-10, 10 being worse: ☐ 0 ☐1 ☐2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Is your condition: ☐ Improving ☐ Unchanged ☐ Worsening

6 HOSPITALIZATION / EXAMINATION HISTORY

Have you been to the hospital for *this* condition? ☐ Yes ☐ No   If yes, name of hospital? ______________________

When did you go? ______________________________   How did you get there? ☐ Ambulance ☐ Self ☐ Others

Were x-rays taken? ☐ Yes ☐ No   If yes, what area(s)? ____

Were you prescribed any medication? ☐ Yes ☐ No   If yes, what medications? ______________________________

Have you seen any other doctor or received any other treatment for your current condition? ☐ Yes ☐ No

If yes, explain ____

Doctor's name and address: ____

Phone #: ____________________ Date(s) seen: ____________________ Diagnosis: ____________________

DIAGNOSTIC TESTING YOU MAY HAVE RECEIVED: (place "X" in boxes that apply)

Test	Region / Body Part(s)	Date(s)	Test	Region / Body Part(s)	Date(s)
☐ Examination	______________	________	☐ EMG / NCV	______________	________
☐ MRI / CT	______________	________	☐ ____________	______________	________

7 HEALTH HISTORY / INJURIES / TREATMENTS

INJURIES YOU MAY HAVE HAD IN THE PAST Description Date (s)

Auto Accident (s) ______________________ ______________

Work Injuries ______________________ ______________

Broken Bones ______________________ ______________

DO YOU CURRENTLY OR IN THE PAST USED: ☐ Alcohol ☐ Tobacco ☐ Drugs (Prescription or Otherwise)

HAVE YOU EVER BEEN DIAGNOSED AS HAVING OR SUFFERING FROM: ***(place "X" in boxes that apply)***

☐ Muscle disorder	☐ Lungs, Asthma	☐ Osteoarthritis
☐ Nervous System Disorder	☐ Broken Bones	☐ Epilepsy
☐ Bone Disorder	☐ Eating Disorder	☐ Alcoholism
☐ Rheumatoid Arthritis	☐ Pace Maker	☐ Drug Addiction
☐ Allergies	☐ Seizures/Convulsions`	☐ Strokes
☐ HIV	☐ A Congenital Disease	☐ Cancer
☐ Gallbladder	☐ Excessive Bleeding	☐ Ulcer
☐ Diabetes	☐ High Blood Pressure	☐ Hernias
☐ Depression	☐ Low Blood Pressure	☐ Ears, eyes, nose, throat
☐ Coughing Blood	☐ Kidney, Bladder (GU)	☐ Tumors
☐ Stomach, Intestines (GI)	☐ Circulatory Problems	☐ Heart Disease

FAMILY HEALTH HISTORY:

Please list all family members medical history: (Father / Mother / Brother / Sister / Grandfather / Grandmother)

Condition:	Relationship:	Condition:	Relationship:
Heart Disease	F ☐ M ☐ B ☐ S ☐ GF ☐ GM ☐	Epilepsy (seizers)	F ☐ M ☐ B ☐ S ☐ GF ☐ GM ☐
High Blood Pressure	F ☐ M ☐ B ☐ S ☐ GF ☐ GM ☐	Kidney Diseases	F ☐ M ☐ B ☐ S ☐ GF ☐ GM ☐
Diabetes	F ☐ M ☐ B ☐ S ☐ GF ☐ GM ☐	Mental Retardation	F ☐ M ☐ B ☐ S ☐ GF ☐ GM ☐
High Cholesterol	F ☐ M ☐ B ☐ S ☐ GF ☐ GM ☐	Osteoarthritis	F ☐ M ☐ B ☐ S ☐ GF ☐ GM ☐
Stroke	F ☐ M ☐ B ☐ S ☐ GF ☐ GM ☐	Migraine Headaches	F ☐ M ☐ B ☐ S ☐ GF ☐ GM ☐
Cancer	F ☐ M ☐ B ☐ S ☐ GF ☐ GM ☐	Osteoporosis	F ☐ M ☐ B ☐ S ☐ GF ☐ GM ☐
Thyroid Disorders	F ☐ M ☐ B ☐ S ☐ GF ☐ GM ☐	Other:	F ☐ M ☐ B ☐ S ☐ GF ☐ GM ☐

8 YOUR DOCTORS

Please List ALL Doctors involved in your healthcare, present and past. (Use back if necessary)

	Name	*Phone*
Primary / Family Doctor:		
Orthopedic Doctor:		
Pain Management:		
Neurologist:		
Chiropractor:		

9 AUTHORIZATION FOR TREATMENT

I hereby authorize the Doctor to treat my condition as he/she deems appropriate and to furnish any authorized requests for information regarding treatment. It is understood and agreed that the amount paid to the Doctor for x-rays is for examination only and the x-ray negatives will remain the property of this office. They will be kept on file where they may be seen at any time while the patient is being treated at this office. The patient also agrees that he/she is responsible for all bills incurred at this office. (The Doctor will not be held responsible for any preexisting medically diagnosed conditions, nor for any medical diagnosis). The patient also agrees that statements made in this questionnaire are true and correct.

Patient's Signature:______________________ Date:______________

Guardian's Signature:______________________ Date:______________

Update Health Information

General Information

First Name ______________________
Middle Initial ______________________
Last Name ______________________
Race (circle only 1) American Indian Alaska Native
Asian White
Black or African American
Native Hawaiian Other Pacific Islander
Declined to State

For Office Use Only
Account Number ______________
Patient Height ______________
Patient Weight ______________
Patient BMI ______________
Patient Blood Pressure ______________

Ethnicity (circle only 1) Declined to State Hispanic or Latino
Not Hispanic or Latino
Preferred Language ______________________
Email Address ______________________

Smoking Status (circle only 1) Current Every Day Smoker Smoking Start Date: ________ End Date: ________
Current Some Day Smoker
Former Smoker
Never Smoker
In an effort to quit smoking, I am currently taking: ______________________

Do you have any allergies to medication? Yes No
If Yes, please indicate the following:

Allergy: ______________ Allergy: ______________
Reaction: ______________ Reaction: ______________
Start Date: ______________ Start Date: ______________
End Date: ______________ End Date: ______________

Allergy: ______________ Allergy: ______________
Reaction: ______________ Reaction: ______________
Start Date: ______________ Start Date: ______________
End Date: ______________ End Date: ______________

Are you currently taking any new medication since your last visit? Yes No
If Yes, please indicate the following:

Medication: ______________ Medication: ______________
Route: Oral Route: Oral
Intravenous Intravenous
Other: ______________ Other: ______________
Frequency: ______________ Frequency: ______________
Began Use: ______________ Began Use: ______________
Discontinued Use: ______________ Discontinued Use: ______________

Medication: ______________ Medication: ______________
Route: Oral Route: Oral
Intravenous Intravenous
Other: ______________ Other: ______________
Frequency: ______________ Frequency: ______________
Began Use: ______________ Began Use: ______________
Discontinued Use: ______________ Discontinued Use: ______________

Patient Name: ______________ **The Neck Disability Index** ***Date:*** ________

Please rate the severity of your pain by circling a number below: **Score:** __________

No pain | *0 1 2 3 4 5 6 7 8 9 10* | *Unbearable Pain*

Instructions: This questionnaire has been designed to give the doctor information as to how your NECK PAIN has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

SECTION 1 – PAIN INTENSITY

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

SECTION 2 – PERSONAL CARE *(Washing, Dressing, etc.)*

- ☐ I can look after myself normally, without causing extra pain.
- ☐ I can look after myself normally, but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help, but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed; I wash with difficulty and stay in bed.

SECTION 3 – LIFTING

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights, but it gives extra pain.
- ☐ Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- ☐ Pain prevents me lifting heavy weights off the floor, but I can manage light to medium weights when conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift of carry anything at all.

SECTION 4 – SLEEPING

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr sleepless).
- ☐ My sleep is mildly disturbed (1-2 hrs sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs sleepless).
- ☐ My sleep is greatly disturbed (3-5 hrs sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs sleepless).

SECTION 5 – READING

- ☐ I can read as much as I want to, with no pain in my neck.
- ☐ I can read as much as I want to, with slight pain in my neck.
- ☐ I can read as much as I want to, with moderate pain in my neck.
- ☐ I can't read as much as I want, because of moderate pain in my neck.
- ☐ I can hardly read at all, because of severe pain in my neck.
- ☐ I cannot read at all.

SECTION 6 – CONCENTRATION

- ☐ I can concentrate fully when I want to, with no difficulty.
- ☐ I can concentrate fully when I want to, with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

SECTION 7 – HEADACHES

- ☐ I have no headaches at all.
- ☐ I have slight headaches that come infrequently.
- ☐ I have moderate headaches that come infrequently.
- ☐ I have moderate headaches that come frequently.
- ☐ I have severe headaches that come frequently.
- ☐ I have headaches almost all the time.

SECTION 8 – WORK

- ☐ I can do as much work as I want to.
- ☐ I can do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all

SECTION 9 – DRIVING

- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want, with slight pain in my neck.
- ☐ I can drive my car as long as I want, with moderate neck pain.
- ☐ I can't drive my car as long as I want, because of moderate pain in my neck.
- ☐ I can hardly drive at all, because of severe pain in my neck.
- ☐ I can't drive my car at all.

SECTION 10 – RECREATION

- ☐ I am able to engage in all my recreation activities with no neck pain.
- ☐ I am able to engage in all my recreation activities with some
- ☐ neck pain.
- ☐ I am able to engage in most, but not all of my usual recreation activities, because of pain in my neck.
- ☐ I am able to engage in few of my recreation activities, because of pain in my neck.
- ☐ I can hardly do any recreation activities, because of neck pain.
- ☐ I can't do any recreational activities at all.

*Patient Name:*________________ **Oswestry Low Back Pain Scale** *Date:*________

Please rate the severity of your pain by circling a number below: *Score:*________

No pain	0	1	2	3	4	5	6	7	8	9	10	*Unbearable Pain*

Instructions: This questionnaire has been designed to give the doctor information as to how your LOW BACK PAIN has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

SECTION 1 – PAIN INTENSITY

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is severe.
- ☐ The pain is severe and does not vary much.

SECTION 2 – PERSONAL CARE (Washing, Dressing, etc.)

- ☐ I would not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increase the pain but I manage not to change my way of doing it.
- ☐ Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain I am unable to do some washing and dressing without help.
- ☐ Because of the pain I am unable to do any washing dressing without help.

SECTION 3 – LIFTING

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights, but it gives extra pain.
- ☐ Pain prevents me lifting heavy weights off the floor.
- ☐ Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- ☐ Pain prevents me lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift light weights at most.

SECTION 4 – WALKING

- ☐ I have no pain on walking.
- ☐ I have some pain walking, it does not increase with distance.
- ☐ I cannot walk more than 1 mile without increasing pain.
- ☐ I cannot walk more than ½ mile without increasing pain.
- ☐ I cannot walk more than ¼ mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

SECTION 5 – SITTING

- ☐ I can sit in any chair as long as I like.
- ☐ I can sit only in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than ½ hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain immediately.

SECTION 6 – STANDING

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain on standing but it does not increase with time.
- ☐ I cannot stand for longer than 1 hour without increasing pain.
- ☐ I cannot stand for longer than ½ hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain immediately.

SECTION 7 – SLEEPING

- ☐ I get no pain in bed.
- ☐ I get pain in bed, but it does not prevent me from sleeping well.
- ☐ Because of pain my normal nights sleep is reduced by less than one-quarter.
- ☐ Because of pain my normal nights sleep is reduced by less than one-half.
- ☐ Because of pain my normal nights sleep is reduced by less than three-quarter.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 – SOCIAL LIFE

- ☐ My social life is normal and gives me no pain.
- ☐ My social life is normal, but it increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- ☐ Pain has restricted my social life and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of the pain.

SECTION 9 – TRAVELING

- ☐ I get no pain when traveling.
- ☐ I get some pain when traveling but none of my usual form of travel make it any worse.
- ☐ I get extra pain while traveling, but it does not compel me to seek alternate forms of travel.
- ☐ I get extra pain while traveling which compels me to seek alternative forms of travel.
- ☐ Pain restricts me to short necessary journeys under ½ hour.
- ☐ Pain restricts all forms of travel.

SECTION 10 – CHANGING DEGREE OF PAIN

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates, but is definitely getting better.
- ☐ My pain seems to be getting better, but improvement is slow.
- ☐ My pain is neither getting better or worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

The Roland-Morris Low Back Pain and Disability Questionnaire

Patient Name______________________________ **Date:** _______________ **Score** __________

Instructions: When your back hurts, you may find it difficult to do some of the things you normally do. Mark only the sentences that describe you currently:

- ☐ I stay at home most of the time because of my back.
- ☐ I change position frequently to try to get my back comfortable.
- ☐ I walk more slowly than usual because of my back.
- ☐ Because of my back, I am not doing any jobs that I usually do around the house.
- ☐ Because of my back, I use a handrail to get upstairs.
- ☐ Because of my back, I lie down to rest more often.
- ☐ Because of my back, I have to hold on to something to get out of an easy chair.
- ☐ Because of my back, I try to get other people to do things for me.
- ☐ I get dressed more slowly than usual because of my back.
- ☐ I only stand up for short periods of time because of my back.
- ☐ Because of my back, I try not to bend or kneel down.
- ☐ I find it difficult to get out of a chair because of my back.
- ☐ My back is painful almost all of the time.
- ☐ I find it difficult to turn over in bed because of my back.
- ☐ My appetite is not very good because of my back.
- ☐ I have trouble putting on my socks (or stockings) because of the pain in my back.
- ☐ I can only walk short distances because of my back pain.
- ☐ I sleep less well because of because of my back.
- ☐ Because of my back pain, I get dressed with the help of someone else.
- ☐ I sit down for most of the day because of my back.
- ☐ I avoid heavy jobs around the house because of my back.
- ☐ Because of back pain, I am more irritable and bad tempered with people than usual.
- ☐ Because of my back, I go upstairs more slowly than usual.
- ☐ I stay in bed most of the time because of my back.

Surfside Chiropractic Center Consent To Services

PATIENT'S RIGHTS **Pt. Initials_______**

The Surfside Chiropractic Center (SCC) respects the unique differences of our patients, and will ensure that health care ethics are maintained for all patients. The following rights will be exercised on our patients' behalf:

1. The patient has the right to considerate and respectful care.
2. The patient has the right to and is encouraged to obtain from the doctor relevant, current, and understandable information concerning diagnosis, treatment, and prognosis.
3. The patient has the right to know the identity of the doctor, staff, and all involved in patient care.
4. The patient has the right to make decisions about the plan of care prior to and during the course of treatment, and to refuse a recommended treatment or plan of care to the extent permitted by law, and to be informed of the consequences of this action.
5. The patient has the right to every consideration of privacy.
6. The patient has the right to expect that all communications and records pertaining to his/her care will be treated as confidential, except in cases where reporting is permitted or required by law.
7. The patient has the right to expect reasonable continuity of care when appropriate and to be informed by the doctor of available and realistic patient care options.

CONSENT TO TREATMENT OF A MINOR CHILD *(Under the age of 18)* **Pt. Initials_______**

I authorize Chiropractic &/or Therapy care as deemed necessary to my (relationship)_____________________.

FEMALE PATIENTS *(ONLY)* **Pt. Initials_______**

This is to certify that, to the best of my knowledge, I am NOT pregnant and that SCC has my permission to take x-rays. Beginning date of last menstrual period _____________.

PAYMENT, INSURANCE, MEDICAL RECORDS, AND USE OF NAME (for treatment; if you take care) **Pt. Initials_______**

I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.

I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum in now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, and fees for products or professional services rendered will be immediately due and payable.

CONSENT TO X-RAY ASSIGNMENT AGREEMENT **Pt. Initials_______**

I consent to allow SCC to use the services of an outside Radiologist if needed to insure the highest quality interpretation of my x-rays. I acknowledge that these services are separate from those of the clinic where I am receiving care, and that the charges for these services will be submitted to my insurance carrier, Workers' Compensation carrier of State Bureau, and/or to my attorney in the case of personal injury.

In the event that I receive payment for these services, I agree to promptly remit payment to the Radiologist or radiology service.

I assign my insurance benefits and rights to payment to the Radiologist to the extent of their charges, and authorize them, or their agents, to bill and release information to my insurance company, attorney, and/or any third-party payer. I authorize my treating physician, insurance company, attorney, and/or third-party payer to provide the Radiologist or their agents with any information concerning my claim, their services, and/or payment for the services provided.

CONSENT TO CHIROPRACTIC &/or THERAPY SERVICES **Pt. Initials_______**

I hereby request and consent to comprehensive examinations (chiropractic, orthopedic &/or neurological), chiropractic adjustments/treatments *(and other procedures including various modes of therapy modalities, including soft tissue mobilization, therapeutic exercises, stretching, posture and ergonomic training, and home exercise program)*, nutritional counseling/advice, and diagnostic x-rays by SCC *(& it's staff)*, who now or in the future treat me in this office. I have had an opportunity to discuss with the SCC Staff the nature and the purpose of the treatment indicated. I understand that results are not guaranteed and am informed that, as in the practice of medicine, the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor(s) to be able to anticipate and explain all risks and complications, and wish to rely on the doctor(s) to exercise judgment during the course of any procedure which the doctor(s) feels at the time is in my best interest. I have read, or have had read to me, the full above consent and have also had an opportunity to ask questions about its content and by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for any future conditions for which I seek treatment by SCC and/or employed staff.

NO SHOW/CANCELLATION/LATE POLICY

SCC has the right to charge a fee of $25.00 for appointments not cancelled within 24 hours of scheduled time or not showing for scheduled appointment and payment will be due on next visit. If patients show up for appointments more than 15 minutes late we may re-schedule or full treatment will not be given.

Pt. Initials _______

By my signature below, I acknowledge that I have read, understand, and agree to the above provisions, and I assign my insurance benefits as described above.

PRINTED_______________________ **SIGNED**___________________________ **DATE**____________