# Berryville Family Chiropractic

_____ _____ _____
First Name and Middle Initial Last Name Date of Birth

_____ **Gender**: ___Male ___Female **Marital Status**: __Single __Married __Divorced __Widowed
Nickname

_____ _____ _____ _____
Address City State Zip

_____ _____ _____ _____
Local or Mailing Address (if different from above) City State Zip

_____ _____ _____
Home Phone Cell Phone Email Address

_____ _____ _____
Occupation Spouse's Name Spouse's Phone

_____ _____ _____
Emergency Contact (if other than spouse) Phone Relationship

_____ _____ _____
Whom may we thank for referring you? Your Height Your Weight in lbs

_____ _____
Prior Chiropractic Care- Who? Last Visit

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Reason for this visit

**FAMILY HISTORY:** Please check any conditions that any blood relatives have been diagnosed with;

___ Arthritis ___High Blood Pressure ___Stroke ___Heart Attack ___Cancer ___Diabetes ___Epilepsy ___Scoliosis

## INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of procedures, including chiropractic adjustments, examinations and any supportive therapies on me (or on the patient named above, for whom I am legally responsible) by Berryville Family Chiropractic and/or other licensed providers and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up providers named below, including those working at this clinic , whether signatories to this form or not.

I have had an opportunity to discuss with the Berryville Family Chiropractic provider and/or office personnel the nature and purpose of these procedures.

I understand and I am informed that, as is with all healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all healthcare treatments, there are some risks to treatment, including, but not limited to, muscle spasms for short period of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the Berryville Chiropractic Center provider to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that treatment is designed to improve health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are ultimately my responsibility, including balances not paid by my insurance company. I also understand that I may be billed for appointments that are missed or not cancelled within 24 hours of the scheduled time. By my signature at the bottom of this page, I agree to be responsible for all reasonable collection fees and attorney's fees incurred should my account be referred for collection.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment at Berryville Family Chiropractic.

## Acknowledgements

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.

Initials_____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Initials_____ I grant permission to be called or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Initials _____ My records are protected under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I authorize Berryville Family Chiropractic to release any information requested by any insurance company, attorney or any doctor that is relative to my examination and treatment. I also authorize the payment of medical benefits directly to Berryville Family Chiropractic.

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.

_____ _____

Signature Today's Date