NEW PATIENT APPLICATION

Welcome to our Practice! Please thoroughly complete all questions. Thank you.

Name: _____ Date: _____

Address: _____

City/State/Zip: _____ E-Mail:_____

Phone: Home _____ Work: _____ Fax: _____

Cell #:_____ Cell Carrier (Circle One): Sprint Verizon T-Mobile AT&T Other_____

Marital status: M/W/D/S Birth date: ____/____/____

Age: _____ Social Security #: _____

Who may we thank for referring you? _____

Which doctor are you here to see? _____

Your prior doctor of chiropractic and address: _____

Chiropractic techniques you've had success with: _____

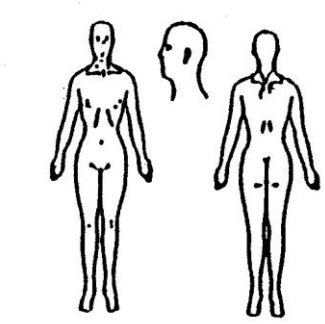
Last time you went to previous doctor of chiropractic _____

General practitioner: _____ City _____

Your employer: _____ Phone number: _____

Employer's address: _____

Occupation: _____ Mark area(s) of Health Concerns



Spouse's name: _____

Children's names & ages: _____

Favorite hobbies or interests: _____

_____

Health reasons for consulting our office:

1. _____ 3. _____
2. _____ 4. _____

How does this problem impact your life? _____
_____

Have you had same or similar problem(s) before? ___ Yes ___ No

How long? _____ Please explain: _____

_____

Father/Mother/Brother/Sister/Children with similar problems?

_____

Is this the result of an auto or work injury? _____ If so, when? _____

Other doctors who have treated this problem: _____

_____

Surgery you have had: _____

Medication(s) you currently take: _____

Is there any chance you are pregnant? Yes___ No___

What have you heard about chiropractic care?

_____

Do you know what a subluxation is? If yes, please describe

_____

What daily rituals for spinal health do you presently practice?

_____

Do you have health insurance? _____ Name of company: _____

Method of payment for first visit:

_____Cash _____Check _____MAC _____Credit Card

The above information is true and accurate to the best of my knowledge. My reason for consultation with the doctor is for evaluation of my physical health and the potential for improvement.

Patient or Guardian Signature: _____

Date: _____/_____/_____

INFORMED CONSENT

If deemed appropriate for my case, I hereby request and consent to the performance of chiropractic adjustments and other procedures, including various modes of physical therapy and diagnostic X-rays on me or on the patient named below, for whom I am legally responsible. Chiropractic Healthcare involves various techniques and modalities to achieve the best possible outcome for the patient. These include, but are not limited to the following:

1. Chiropractic Adjustment/Manipulation: A chiropractic maneuver that utilizes controlled force, leverage direction, amplitude, and velocity and which is directed at specific joints or anatomical regions. Chiropractors commonly use such procedures to influence joint and neurophysiologic function.

2. Electro-Therapy: A therapeutic treatment to aid in the relief of pain and promotion of soft tissue healing. Also causes stimulation of innervated muscle to cause contraction, which helps force fluid out of the lymphatic and interstitial tissues thereby reducing edema. Also helps stimulate the release of endorphins, which are the body natural painkillers.

3. Myofascial Release Technique: Relaxes overactive muscles in and helps stretch chronically shortened muscles. Helps restore normal elasticity to the muscles, ligaments and tendons.

4. Manual Traction: Involves force acting on longitudinal axis to draw structures apart. Induces passive motion into the spine for the purpose of stretching spinals joints and increasing mobility.

5. Mobilization: Movement applied singularly or repetitively within or at the physiologic range of joint motion, without imparting a thrust or impulse, with the goal of restoring mobility.

6. Decompression Therapy: Involves force acting on a longitudinal axis to draw structures apart. Induces passive motion into the spine for the purpose of stretching spinal joints and increasing mobility, done by a computerized device.

7. Dry Needling & Acupuncture and cupping: The insertion of small needles into specific body points to promote energy flow, relieve pain, and increase circulation. Cups are small glass bowls that use vacuum pressure to reduce inflammation and improve blood flow.

It is common for chiropractic adjustments, traction, massage therapy, exercise, etc. to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please tell your treating chiropractor about it.

I understand that, as in the practice of medicine, in the practice of chiropractic there are some risks to the treatment, including but not limited to; fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely upon the doctor to exercise judgment during the course of the procedure, which the doctor feels at the time, based upon the facts then known to him or her is in my best interest. Needling is safe but as with any other treatment there may be side effects including, bruising (common with cupping), numbness, or tingling near the site that may last for a few days, dizziness or fainting. Unusual risks of needles include miscarriage, nerve damage, infection, and organ puncture including lung puncture (pneumothorax). Horizon Chiropractic and its affiliates use disposable sterile needles and maintains a clean, safe environment.

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

Patient Signature and/or Parent Guardian: _____ Date: _____

Print Name: _____

Financial Responsibility Information

- Payment is expected at the time services are rendered and are accepted in the form of check credit card (VISA/MASTERCARD/DISCOVER) and cash.
- If there is no insurance policy the client shall follow the standard office guidelines for payment.
- We will gladly verify insurance benefits and file your primary insurance. The client/insured is responsible of paying estimated amounts (based on quotes by the insurance carrier) at the time services are rendered.
- Any amount not allowed, and/or not covered by the insurance carrier becomes the immediate responsibility of the insured (except in the case of contractual agreements between the provider and the carrier).
- The insured is responsible to know and pay according to the insurance policy and its restrictions, limitations, and guidelines.
- Client/insured (or parent, if minor) is ultimately responsible for any and all fees incurred regardless of quotes or implied insurance or 3rd party insurance carrier involvement.
- A missed massage appointment will be charged in full if not notified in 24 hours prior to appointment time.
- Services are rendered in good faith that timely payment will be made that no account will become delinquent. Any account requiring collection action will incur legal fees that are the responsibility of the client.

I have read and understand the above terms and conditions. A client (or parent, if minor) signature constitutes acceptance.

Client Signature: _____ **Date: _____**