Patient Intake

Name_____ **M/F M/S/W/D** **DOB**_____ **Age**_____

Address_____**City**_____**State**_____**Zip**_____

Daytime Phone#_____ **Email Address**_____

Employer_____**Occupation**_____

Emergency Contact Name_____**Relation**_____**Phone**_____

Health Insurance Information (please show your card)

Name of Company_____**Insured's name**_____**DOB**_____

ID#_____**Group #**_____**Co-pay**_____

Address for claims_____**Claims Dept. Phone#**_____

Reason for today's visit?_____

Do you require an interpreter? Y/N **Females: Are you pregnant? Y/N If so, how far along?**_____

Who referred you?_____

Please Read and Sign

Financial Policy

Basic responsibility for all professional services belong to the patient. Our office will assist you in preparing forms and billing. **You are responsible for any and all deductibles, co-pays and charges not covered by your insurance.** I understand that I am financially responsible for all charges whether or not paid by any third part. I agree that all charges are payable and collectible in this county. I hereby authorize Jeanne Ames, D.C. to make inquiries, endorse drafts and release any information to my insurance company, employer, attorney or benefit plan about my charges. I irrevocably authorize and direct any of these agents to pay what is due for professional services directly to Jeanne Ames, D.C.

Privacy Policy

I consent to the use and disclosure of my protected health information for the purpose of providing treatment to me, for purposes relating to the payment of services and for the Practice's general healthcare operations purposes. I understand that I have the right to request a restriction on the use and disclosure of my protected health information.

Informed Consent

I give permission to Dr. Jeanne Ames, to administer treatment and perform such general procedures as she deems necessary in the diagnosis and treatment of my condition. I understand that, as with any healthcare procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include but are not limited to: muscle strain, disc injuries, dislocations, fractures and cervical myelopathy. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck, leading to or contributing to serious complications, including stroke. This is a very rare event that occurs during manipulation with head rotated and in an extended position- a method of adjusting that is not used in this clinic. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on her to exercise good judgment during the course of the procedures, which she feels at the time, based upon the facts then known, are in my best interest.

I have read the above. By signing below, I state that I have weighed the risks involved in undergoing chiropractic care and have decided that it is in my best interest to undergo the chiropractic treatment recommended. I understand that results are not guaranteed. I intend this consent to cover the entire course of treatment for my present and future conditions(s) for which I seek treatment. I will inform the doctor of any changes in my medical status.

Signature_____**Date**___/___/_____