SARPY CHIROPRACTIC – CONFIDENTIAL HEALTH INFORMATION

www.sarpychiro.com

_____ _____

Today's Date (MM/DD/YYYY) **Your Social Security Number**

_____ _____ _____

Your Last Name **Your First Name** **Your Middle Initial**

_____ _____ _____ _____

Street Address **City** **State** **ZIP Code**

_____ _____ _____ _____ _____

Birth Date (MM/DD/YYYY) **Marital Status** **Height** **Weight** **Spouse's Name**

_____ _____ _____

Home Phone **Cell Phone** **Child's Name and Age**

_____ _____

Email Address **Child's Name and Age**

_____ _____ _____

Your Occupation **Your Employer** **Child's Name and Age**

_____ _____ _____

Emergency Contact **Emergency Contact Phone** **Primary Care Physician**

_____

How can we help you today?

How did you hear about us? ☐ **Google** ☐ **Facebook** ☐ **Let's Talk Papillion** ☐ **Instagram** ☐ **YouTube**

☐ **Referred by:** _____ ☐ **Other:** _____

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 (If patient is under 19 years of age, parent or guardian must initial):

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 to confirm 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 _____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive. I may request a copy of the Clinic's Financial Policy at any time.**

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 concerns.**

If the patient is under 19 years of age, print child's full name: _____

Signature (Parent/Guardian if patient is a minor): _____ Date (MM/DD/YYYY): _____

INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of procedures, including various modes of chiropractic adjustments, examinations, physical therapies, and any other supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the Sarpy Chiropractic 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 the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the Sarpy Chiropractic provider and/or with other office or clinic 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 with all healthcare treatments, there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, and sprains. I do not expect the Sarpy Chiropractic provider to be able to anticipate and explain all the 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 final and no refunds will be issued.

I further understand that there are other treatment options available for my condition. These treatment options include, but are not limited to, self-administered over the counter analgesics; rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants, and pain killers; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and may secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

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.

Name of Patient: _____

Signature of Patient: _____

Name Printed of Guardian/Parent to Patient: _____

Guardian's Relationship to Patient: _____

Guardian/Parental Signature: _____

Date: _____