Bukaty Family Chiropractic · 4269 St. Francis Drive · Hamburg, NY 14075 · Phone: (716) 627-3668
Dr. Christina Bukaty
Dr. Emily Patrick

No Fault Paperwork

After an automobile accident, it is important that you gather the correct information and fill out all applicable documents in order for insurance to cover the medical care you need. Below is some guidance on what you will need.

1. Contact your car insurance. This is true regardless of who was at fault in the accident.
2. Get a claim number from your insurance
3. **Imperative** - fill out all paperwork that your insurance sends you
4. Get copy of police report which should include:
    a. Name of other driver
    b. Insurance of other driver
    c. Policy number of other driver
5. **Imperative** to get the following information
    a. Adjustor name
    b. Adjustor phone number and fax and e-mail

Automobile Accident Questionnaire

Please answer all questions completely and accurately. Please write legibly.

Name: _____ Date: _____

Insurance Information

The following insurance information is in reference to your automobile insurance as it is a No-Fault case.

Insurance Company: _____
Insurance Company Address: _____
Insurance Company City: _____ State: _____ Zip: _____
Insurance Company Telephone: _____ Claim No: _____
Insurance Company Contact Person: _____
Driver of vehicle in which you were injured (if applicable) Name: _____
Have you retained an attorney? YES NO
If yes, name, address, and phone: _____

Accident Information

Please explain in detail how your accident happened. Be specific. Include: how accident occurred, what happened to you in the vehicle, damage to vehicle, if you were wearing a seat belt, how many passengers were in the vehicle, etc.

_____
_____
_____
_____
_____

Name: _____ Date: _____

Date and time of accident: _____
Were you heading *North *South *East *West on_____
Other vehicle was heading *North *South *East *West on_____
Were you struck from Behind Front Passenger Side Driver Side

Were the police notified? NO YES
If yes, was a report filed? NO YES
Were you knocked unconscious? NO YES
Were you wearing your seat belt? NO YES

Have you ever injured this area before? NO YES
If so, when? _____
Did you lose any work time as a result of this accident? NO YES
If yes, how much time? _____
Do any other disease(s) or accidents affect your employment? NO YES
If yes, please explain _____

Before the injury, were you capable of working on an equal basis with others your age? NO YES
Are your work activities restricted as a result of this accident? NO YES
If yes, please explain _____
Are your daily activities affected? NO YES
If yes, please explain _____

Since this injury, are your symptoms IMPROVING GETTING WORSE THE SAME

Please Draw a diagram of the accident below:

AGREEMENT TO PAY MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE OR IF NO FAULT CLAIM IS NOT ALLOWED

Date of Injury: _____ SS#:_____
Injured Person: _____ Address: _____
Employer: _____Address: _____
Insurance Carrier: _____ Address: _____

In the event I fail to prosecute the claim for no-fault for this illness or condition or it is determined by the No-Fault board that the illness or condition is not a direct result of a compensable No-Fault case, I _____ Hereby agree to pay Bukaty Family Chiropractic the usual and customary fees for services rendered to the above-named claimant in the above identified case.

Signature: _____ Date: _____

If signed by other than claimant, fill out below:

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Witness

Name: _____ Date: _____

New York Motor Vehicle No-Fault Insurance Law
Assignment of Benefits Form

I, _____, ("Assignor") hereby assign to Bukaty Family Chiropractic ("Assignee") all rights,
(Print Patient's Name)
privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (No-Fault statute) of the insurance law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____, notwithstanding any other agreement to the contrary.
(Accident Date)

This agreement may be revoked by the assignee when benefits are not payable based upon the assignors' lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for commercial insurance or a statement of claim for any commercial or personal insurance benefits containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, and any person who, in connection with such application or claim, knowingly makes or knowingly assists, abets, solicits or conspires with another to make false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the value of the subject motor vehicle or stated claim for each violation

Print Name: _____Signature: _____

Date: _____

Patient Address: _____ City: _____ State: _____ Zip: _____

Print Name of Provider: _____ Signature: _____

4269 St. Francis Drive, Hamburg, NY 14075

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Welcome to Bukaty Family Chiropractic, PC

We are happy to be taking care of you today!

Patient Information

Name: _____Date: _____DOB: _____Social Security #: _____

Address: _____ City/State/Zip: _____

Home Phone #: _____Cell Phone #: _____ Work Phone #: _____

Single Married Widowed Spouse Name: _____ E-mail Address: _____

Employer: _____ Occupation: _____

Whom can we thank for your referral _____

Insurance Information

Insurance Company: _____ ID#: _____

Group #:_____ Person Responsible for Account: _____

Assignment & Release

I, the undersigned, certify that I (or my dependent) have insurance coverage as stated above and assign directly to Bukaty Family Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the use of this signature on all insurance submissions.

Responsible Party: _____ Date: _____

Accident Information

Is you condition due to an accident: Yes No Type of Accident: Auto Work Home Other

Date of Accident: _____ Did you report this accident? Yes No Report to Whom: _____

Patient Condition

Reason for Visit:_____

How Long: _____ How Often: _____ Is it constant or random: _____

Does it effect you at night: _____ Is the condition getting progressively worse? Yes No

Rate the severity of your pain on a scale of 1 (least pain) to 10 (worst pain): _____

Type of pain (circle all that apply): Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling Cramps Stiffness Swelling

Does the pain interfere with: Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform: Sitting Walking Standing Bending Lying Down Stairs

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Health History

Name: _____ Date:_____

What treatments have you already received for your condition?

☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other_____

Name of other doctor(s) who have treated you for your condition_____

_____

Date of Last: Physical Exam _____ Spinal Exam _____Blood Test_____ Urine Test _____

Spinal X-ray _____Chest X-ray _____ Dental X-ray _____ MRI, CT, Bone Scan _____

Place circle "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	Yes	No	Miscarriage	Yes	No
Alcoholism	Yes	No	Mononucleosis	Yes	No
Allergy shots	Yes	No	Multiple sclerosis	Yes	No
Anemia	Yes	No	Mumps	Yes	No
Anorexia	Yes	No	Night sweats	Yes	No
Appendicitis	Yes	No	Osteoporosis	Yes	No
Arthritis	Yes	No	Pacemaker	Yes	No
Asthma	Yes	No	Parkinson's disease	Yes	No
Bleeding disorders	Yes	No	Pinched nerve	Yes	No
Breast lump	Yes	No	Pneumonia	Yes	No
Bronchitis	Yes	No	Polio	Yes	No
Bulimia	Yes	No	Prostate problems	Yes	No
Cancer	Yes	No	Prosthesis	Yes	No
Cataracts	Yes	No	Psychiatric care	Yes	No
Chemical dependency	Yes	No	Rheumatoid arthritis	Yes	No
Chicken pox	Yes	No	Rheumatic fever	Yes	No
Diabetes	Yes	No	Scarlet fever	Yes	No
Emphysema	Yes	No	Stroke	Yes	No
Epilepsy	Yes	No	Suicide attempt	Yes	No
Fractures	Yes	No	Thyroid problems	Yes	No
Glaucoma	Yes	No	Tonsillitis	Yes	No
Goiter	Yes	No	Tuberculosis	Yes	No
Gonorrhea	Yes	No	Tumors/growths	Yes	No
Gout	Yes	No	Typhoid fever	Yes	No
Heart disease	Yes	No	Ulcers	Yes	No
Hepatitis	Yes	No	Vaginal infections	Yes	No
Herpes	Yes	No	Venereal disease	Yes	No
High cholesterol	Yes	No	Whooping cough	Yes	No
Kidney disease	Yes	No	Other	Yes	No
Liver disease	Yes	No			
Measles	Yes	No			
Migraines	Yes	No			
Headaches	Yes	No			

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Are you pregnant? No Yes Due Date_____

Family History

Do/Did you or your mother/father/brother/sister have:

Cardiovascular Disease	No	Yes	Explain_____
Cancer	No	Yes	Explain_____
Stroke	No	Yes	Whom_____
Diabetes	No	Yes	Whom_____

Name: _____ Date:_____

Injury and Surgery History	**Description**	**Date**
Surgical History	_____	_____
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones / Dislocations	_____	_____
Sprains / Strains	_____	_____
Car Accidents	_____	_____

Social History

Circle all that apply:

Exercise: None Moderate Daily Heavy Describe_____

Work Activity: Sitting Standing Light Labor Heavy Labor

Smoking History: None Packs/Day_____ For how long _____

Alcohol Consumption: None Drinks/Week_____ **Coffee/Caffeine** None Cups/Day _____

Stress Levels: Low Medium High Reason_____

Medications	**Vitamins/Herbs/Minerals**	**Allergies**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pharmacy Name: _____ ☐ None ☐ No Known Allergies

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Name: _____ Date:_____

Please circle if you have any of these HEALTH warning signals:

Headaches	No	Yes	Mild	Moderate	Severe	When? _____
Dizziness	No	Yes	Mild	Moderate	Severe	When? _____
Blurred Vision	No	Yes	Mild	Moderate	Severe	When? _____
Concentration	No	Yes	Mild	Moderate	Severe	When? _____
Depression	No	Yes	Mild	Moderate	Severe	When? _____
Nervousness	No	Yes	Mild	Moderate	Severe	When? _____
Difficulty Sleeping	No	Yes	Mild	Moderate	Severe	When? _____
Loss of energy	No	Yes	Mild	Moderate	Severe	When? _____
Buzz/Ring in ears	No	Yes	Mild	Moderate	Severe	When? _____
Heart Palpitations	No	Yes	Mild	Moderate	Severe	When? _____

General Problems

Head	No	Yes	Mild	Moderate	Severe	When? _____
Sinuses	No	Yes	Mild	Moderate	Severe	When? _____
Neck Pain	No	Yes	Mild	Moderate	Severe	When? _____
Shoulder Problems	No	Yes	Mild	Moderate	Severe	When? _____
Upper Back	No	Yes	Mild	Moderate	Severe	When? _____
Mid Back	No	Yes	Mild	Moderate	Severe	When? _____
Chest Pain	No	Yes	Mild	Moderate	Severe	When? _____
Heart / High BP	No	Yes	Mild	Moderate	Severe	When? _____
Lung	No	Yes	Mild	Moderate	Severe	When? _____
Respiratory	No	Yes	Mild	Moderate	Severe	When? _____
Indigestion	No	Yes	Mild	Moderate	Severe	When? _____
Bladder	No	Yes	Mild	Moderate	Severe	When? _____
Liver	No	Yes	Mild	Moderate	Severe	When? _____
Kidney	No	Yes	Mild	Moderate	Severe	When? _____
Urinary	No	Yes	Mild	Moderate	Severe	When? _____
Colon	No	Yes	Mild	Moderate	Severe	When? _____
Constipation	No	Yes	Mild	Moderate	Severe	When? _____
Low Back	No	Yes	Mild	Moderate	Severe	When? _____
Hip Pain	No	Yes	Mild	Moderate	Severe	When? _____
Leg Pain	No	Yes	Mild	Moderate	Severe	When? _____
Poor Circulation	No	Yes	Mild	Moderate	Severe	When? _____
Thyroid	No	Yes	Mild	Moderate	Severe	When? _____
Anxiety Disorders	No	Yes	Mild	Moderate	Severe	When? _____

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Financial Policy Agreement

Our first concern in this office is to provide you, our patient, with excellent chiropractic care. If you have Chiropractic Insurance, we are interested in you receiving maximum benefits.

However, please be advised:

1. **Your insurance policy is a legal contract between you, your employer, and the Insurance Company. We, as healthcare providers, are NOT a party to that contract.**
2. We are contracted in-network with: Independent Health, Blue Cross Blue Shield, Empire, Aetna, United Health Care. We also accept Worker's Compensation, No Fault and Medicare.
3. "Usual & Customary" is a term used by the Insurance Company instead of **"our benefits are low."** Usual and customary fees are reviewed on an average of once every ten years. The key is, you will get back only what your employer puts in…less profits of the insurance company.
4. **You remain ultimately responsible for all charges incurred in this office.**
5. **You signature is your acknowledgement that you are FINANCIALLY RESPONSIBLE for ALL UNPAID charges by your insurance company.**

☐ **Insurance:** If you have health insurance that covers chiropractic care, and our office is in-network with our insurance, we will submit your claim to your insurance company. Please note that your designated chiropractic co=pay will be paid in full to our office at each visit. You will be responsible for payment of any non-covered amounts your insurance company does not pay to our office including deductibles and co-insurances.

Patient Name_____ Insurance Company_____

Patient Signature _____ Date_____

☐ **No Insurance**: If you do not have health insurance, have out-of-network coverage, **or decide to OPT OUT of using your health insurance policy,** you will be responsible for payment of our regular office fees at time of service. You may also purchase one of our pre-paid visit plans. *
Please not that our office WILL NOT BACK BILL ANY CLAIM DATES if you decide to utilize your health insurance policy in the future.

*Pre-paid visit plans, co-payments, & special discounts **cannot** be submitted to your insurance company for reimbursement *but they can be submitted to a flex spending account (FSA) for reimbursement.*

Having health insurance does NOT guarantee payment of services.

For your convenience, we accept cash, personal checks*, MasterCard, Visa, and Discover. *please note that any personal checks returned for non-sufficient funds will be charged an additional fee.

All questions regarding insurance and other financial matters should be addressed to our Office Manager or our Medical Biller. We want you to be comfortable dealing with these matters and believe open communication will enhance the positive outcome we all desire.

I, (print name) _____ have read & understand & agree to the above policies.

Patient Signature: _____ Date: _____

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Text Reminder Permission

As the age of technology keeps growing, our office would like to be a part of that growth and are now utilizing our *text reminder system.* I order for us to do this, we need the information below authorized from you to put in our computer system. Text reminders go out the day before appointments.

Patient Name (please print): _____

Cell Phone Number with Area Code: _____

Cell Phone Carrier (ex: Verizon, Sprint, etc…): _____

Email Address: _____

I hereby authorize BUKATY FAMILY CHIROPRACTIC to text the above cell phone number for appointment reminders.
*Initial*_____

I hereby authorize BUKATY FAMILY CHIROPRACTIC to email me upcoming events and other information notices.
*Initial*_____

Please note: The appointment texting through our patient software program is for appointment reminders only! Please still feel free to use our regular texting line for information, appointment changes and cancellations, etc. That number is 716-771-2320.

Patient Records of Disclosure

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (Check all that apply)

- ☐ OK to confirm your appointments by email, text or phone
- ☐ OK to discuss your condition with any members of you family. If yes, provide names: _____
- ☐ OK to leave message with detailed information or call back number
- ☐ OK to leave message with call back number only
- ☐ OK to mail postcards to home
- ☐ OK to use name in waiting room
- ☐ OK to use your name on the referral board

We utilize an open therapy room. We make good faith attempts to keep our conversations at a low level. We offer every patient the opportunity to be treated in a private room if requested.

Patient Signature: _____ Date: _____

Print Name: _____ DOB: _____

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Medical Release Form

1. **I HEREBY AUTHORIZE:**

☐ Release information to: _____Relationship to Patient: _____

☐ Name of Health Care Provider, Street Address, City, State, Zip Code

_____

2. **INFORMATION REGARDING:**

_____ _____
(Print First and Last Name) (Date of Birth)

3. **TYPE OF INFORMATION TO BE DISCLOSED:**
   a. Records regarding treatment for:
   _____
   b. Records regarding treatment for:
   _____
   c. Specific information requested (please specify below):

___ History and Physical ___ Consultations ___SOAP notes ___ X-Ray ___ Other (Specify): _____

4. **YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:**

Right to Inspect or Copy the Health Information to Be Used or Disclosed
I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting The Medical Records Department.

Right to Receive Copy of This Authorization
I understand that I am under no **obligation to sign this form and that** the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment or payment on my decision to sign this authorization.

Right to Revoke This Authorization
I understand that I may revoke this authorization in writing at any time. To obtain information on how to revoke my authorization or to receive a copy of my revocation, I may contact the Medical Records Department. I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

Patient Signature _____ Date: _____

Office Staff _____ Date: _____

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NOTICE OF PRIVACY PRACTICES (HIPAA NOTICE)

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record:

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record:

You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications:

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share:

You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-packet in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information:

You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice:

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically, we will provide you with a paper copy promptly.

Choose someone to act for you:

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated:

You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W.,

Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints. We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

Share information with your family, close friends, or others involved in your care. Share information in a disaster relief situation. Include your information in a hospital directory. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

Marketing purposes. Sale of your information. Sharing of psychotherapy notes.

In the case of fundraising:

We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways:

Treat you:

We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization:

We can use and share your health information to run our practice, improve your care, and contact your when necessary. Example: We use health information about you to manage your treatment and services.

Bill for your services:

We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues:

We can share health information about you for certain situations such as preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, preventing or reducing a serious threat to anyone's health or safety.

Do research:
We can use or share your information for health research.

Comply with the law:
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests:
We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director:
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests:
We can use or share health information about you for worker's compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, for special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions:
We can share heath information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain to privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of This Notice:
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request.

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Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.
Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease of infirmity.
Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which cases alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximal health potential.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. No do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate the major interference from spinal subluxations. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments. However, we may use other procedures to help your body hold the adjustments.

I, _____ have read and fully understand the above statements.
Print Name

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

Patient Signature: _____ Date: _____

For Minors: I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and herby grant permission for my child to receive chiropractic care

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the doctors have my permission to perform an x-ray evaluation.

Patient Signature: _____ Date: _____