Albanese Chiropractic

Terms of Acceptance and Consent for Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental, and social well-being not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks, and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____	_____	_____
Print Name	Signature	Date

Consent to evaluate and adjust a minor child:

I, _____, being the parent or legal guardian of _____ have read and fully understand the above Consent for Care and hereby grant permission for my child to receive chiropractic care.

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Confidential Patient Information

Full Name _____ Date _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____
Date of Birth _____ Age _____ Sex _____
Email _____ Social Security # _____

Father's Name _____ Cell _____
Address (if different from above) _____

Mother's Name _____ Cell _____
Address (if different from above) _____

Who may we thank for referring you to our office? _____

Health Assessment

Have you ever seen a Chiropractor? Y N For what reason? _____

Purpose of this visit: ___ Wellness Check-up ___ Accident ___ Sports Injury ___ Other (please explain)
_____

If you are experiencing symptoms, when did they first appear? _____
_____

Type of accident/injury describe in detail (if applies): _____
_____
_____

Type of birth: ____ Vaginal ____ Breech ____ Cesarean Hours of labor _____

Difficulties during pregnancy, labor, delivery _____

Length of time breast feeding _____ Length of time formula fed _____

Rate the quality of the following 1-10 (10 being the best, 1 being the lowest)

Overall Health ____ Diet ____ Rest/Sleep ____ Stress ____, major stress is: _____

Exercise hours/week _____ Hours of sitting/driving per week _____ Caffeinated drinks/day _____

Family Health History (Diseases, Chronic Conditions, etc.) _____
_____

Please list hobbies and activities you participate in: _____
_____

List medications currently taking (prescription and non-prescription): _____
_____

Please list year and type of surgeries: _____
_____

Please check any of the following you are experiencing or have experienced in the past:

Dizziness	Hip Pain	Stroke	Asthma	Gas
Headaches	Arm Pain	Cancer	Allergies	Nausea
Poor appetite	Neck Pain	Hernia	Hay Fever	Diarrhea
Nervousness	Wrist Pain	Diabetes	Sore Throats	Indigestion
Fainting	Shoulder Pain	Liver Problem	Ear Infections	Constipation
Fatigue	Mid Back Pain	Heart Condition	Sinus Problem	Stomach
Skin Conditions	Low Back Pain	Kidney Problem		
Vision Problems		Bladder Problem		
Muscle Weakness		Thyroid Condition		
		High Blood Pressure		

Females:

PMS	Bed Wetting, frequency _____	Colic
Excessive Flow	Inverted Feet	Broken Bones _____
Painful Menses	Ear Infections, frequency _____	Growing Pains_____
Irregular Cycle	Frequent Colds, frequency _____	Backpack _____lbs.
Date of Last Period		ADD/Hyperactivity
Are you pregnant? _____ Y ____N		Behavior Problems _____

Other: _____
_____
_____

Complete only if patient is not the primary insured:

Name of Insured _____
___ Male ___ Female Insured's Date of Birth _____ Phone _____

Address (if different) _____
Patient's relationship to primary insured _____
Insured's Social Security Number _____

Primary Insured's Employer _____

Signature _____ Date _____

I authorize Albanese Chiropractic to accept assignment and direct payment for insurance reimbursement. Payment is expected at the time service is rendered, unless other arrangements have been made. I agree to pay a Finance Charge of 1.5% per month on balances over thirty (30) days past due, which is an Annual Percentage Rate of 18%. I understand a $35 fee will be charged to my account for any returned bank checks per each occurrence. If this Office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse Albanese Chiropractic for all costs of such collection efforts, including, but not limited to, all court costs, all attorney fees in the amount of thirty- three and one- third percent (33 ⅓%) and any interest accrued at 1.5% per month.

_____

Consent For Chiropractic Care of a Minor: I hereby authorize the Doctor to administer an Examination, X-Rays, and Chiropractic care as deemed necessary.

Parent or Legal Guardian _____ **Date** _____

_____