

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 _____ Social Security # _____
Date of Birth _____ Age _____ Sex _____ Marital Status M S W D
Cell Phone _____ Email _____

Employer _____ Position _____
Business Address _____
Business Phone _____

Spouses Name _____ Spouses Employer _____
Name and Age of Children _____

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

Health Assessment

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

If yes, were you given maintenance care recommendations? _____

Major Complaint(s) _____

Have you ever had this condition before? If yes, please describe: _____

What are your health goals? _____

Do you have a plan to reach your health goals? _____

Rate the quality of the following on a scale from 1-10 (10 being the best, 1 being the lowest)

Diet _____ Exercise _____, How often do you Exercise _____

Rate your current level of stress (10-High, 0-None): _____

Main causes of your stress: _____

What areas of your health would you like to change or improve? _____

Please list hobbies and activities you participate in: _____

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

Please list year and type of surgeries: _____

Health Warning Signs

Please check any of the following you have experienced in the past 12 months:

- | | | | | |
|--|--|--|---|---------------------------------------|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Stroke | <input type="checkbox"/> Asthma | <input type="checkbox"/> Gas |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Cancer | <input type="checkbox"/> Allergies | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Hernia | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Wrist Pain | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sore Throats | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Ankle Swelling | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Liver Problem | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Sinus Problem | <input type="checkbox"/> Stomach |
| <input type="checkbox"/> Skin Conditions | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Kidney Problem | | |
| <input type="checkbox"/> Vision Problems | | <input type="checkbox"/> Bladder Problem | | |
| <input type="checkbox"/> Muscle Weakness | | <input type="checkbox"/> Thyroid Condition | | |
| | | <input type="checkbox"/> High Blood Pressure | | |

Males:

- Painful Urination
- Frequent Urination
- Hesitancy Upon Urinating

Females:

- PMS
- Hot Flashes
- Excessive Flow
- Painful Menses
- Irregular Cycle
- Date Of Last Period _____
- Are you pregnant? ____ Y ____ N

Children:

- Bed Wetting
- Inverted Feet
- Ear Infections
- Frequent Colds
- ADD/Hyperactivity

Other: _____

Complete only if patient is not the primary insured:

Name of Insured _____

Address: _____

Insured's Social Security Number _____

____ Male ____ Female Insured's Date of Birth _____ Phone _____

Patient's relationship to primary insured _____

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 1/3%) 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 _____
