PEDS NPT

CHIRO HEALTH

CARING FOR THE WHOLE PERSON

The information collected on this form is essential if we are to render the best professional care possible. We appreciate your consideration in filling this out completely so we have accurate records.

Personal Info

Last Name: _____ First Name: _____ MI: _____ Suffix: _____

DOB: ____/____/_____ Sex: M F Age: _____ SSN: _____/_____/_____ Weight: _____

Height: _____ Mom/Dad Name: _____

Address: _____ City: _____ St: _____ Zip:_____

Home PH: (____)_____ Cell PH: (____)_____ Email: _____

Insurance

Insurance Company: _____ (Please present card) Relation to Primary Holder: _____

ID No: _____ Group No: _____ Plan Name: _____

No of Visits: _____ Deductible amt: $ _____ Co-pay amt: $ _____

About your Condition

What brings you into the clinic: _____

_____

How long: ☐ Just today ☐ A few days ☐ Several days ☐ A few weeks ☐ Months ☐ Years

Did it begin: ☐ Gradually ☐ Suddenly Is it getting worse? Y N Is this due to an injury? Y N

What makes it worse: _____

What makes it better: _____

Consent to Evaluate & Adjust a Minor Child

I, _____, being the parent/legal guardian of _____, have read and fully understand the ***Informed Consent*** *and additional documentation, thereby grant permission for my child to receive chiropractic care by Dr. Mark E. Lee DC.*

Patient Signature: _____ **Date:** _____/_____/ _____

Office Use Only

Patient Category: ☐ Chiropractic ☐ Nutrition ☐ PI/Auto

Pay Type: ☐ Cash ☐ Insurance ☐ Medicare ☐ PI

# of Visits: _____ Co-pay Amt: $_____ Prepaid: Y N

Addon Type: ☐ Standard Process ☐ Pure Trim ☐ Sombra ☐ Lifewave

Notes/Nutrition: _____

_____

_____

_____

_____

(CONTINUE ON BACK)

Informed Consent

Risk factors

Doctors of Chiropractic (DC), Md and DPT who use manual therapies such as spinal or extremity adjustments and/or therapies are required to advise patients that there may be some risk associated with such treatment. In particular, you should know that:

- While very rare, reports of fracture to bone, disk injuries, damage to muscles or ligaments have occurred following adjustments. In most of these cases, osteoporosis and/or serious degenerative diseases are a factor. ***Please let your doctor know of these conditions prior to any treatments***.
- While extremely rare, reported cases of stroke following a cervical adjustment have been noted. However, the possibility of a cervical related stroke has been estimated to occur in one to every million to five million adjustments.

You have choices. You may choose to receive the medical model of care, which could include drug therapy or surgery. Other therapists may be able to perform similar treatment protocols as well. The risk of such may be more, less, or equal to chiropractic.

Your treatment is designed to provide the optimum conditions to restore and maintain good health. Duration of treatment is based upon the nature of the problem. Treatment duration is only an approximation of time or a number of treatments based upon similar instances or the opinion of the doctor. This does not guarantee an outcome, nor is it a contract of an kind.

Please read and sign.

I acknowledge I have discussed or had the opportunity to discuss the nature of the information presented and therefore consent to chiropractic examination, adjusting and therapy.

Patient Signature: _____ Date: _____/_____/ _____

Protected Privacy

We are committed to do everything possible to protect your "non-public personal information". However, there are times when we must collect and send this information for and in your behalf, to be paid for services rendered. You have the right to inspect your personal healthcare information. You also have the right to amend any errors you may find in your record.

Authorization to Release Medical Information

I authorize Dr. Mark E. Lee DC, Lee Family Chiropractic/Chiro Health, and/or staff to release my personal healthcare information necessary to receive payment of services by any, or all parties associates with me and my healthcare treatment. I will not and do not hold Dr. Mark E. Lee DC or anyone associated with his clinic personally liable for the release of this information when deemed necessary to do so.

Patient Signature: _____ Date: _____/_____/ _____