



HEALTH ASSESSMENT

PERSONAL

**** Please provide the front desk with your Driver's License or a Valid I.D., Auto Insurance Policy page and Health Insurance**

Date: _____ How did you hear about **Dr. Dilo (Who referred you)?**: _____

Name: _____ Home Tel: (____) ____-____ Work: (____) ____-____ Cell: (____) ____-____

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

Birth date: __/__/____ Age: ____ Sex: M / F SS#: _____-____-____ Marital Status: _____ Driver's Lic.#: _____ State: _____

Spouse: _____ Emergency Contact: _____ Phone: (____) ____-____

eMail: _____ Would you like to receive an occasional newsletter? Yes No

Occupation: _____ Employer: _____ Address: _____

HEALTH INSURANCE

Your Health Insurance Co.: _____ Policy #: _____ Group #: _____

Address: _____ City: _____ State: _____ Zip: _____ Phone: (____) ____-____

Coverage for Chiropractic: Yes No Deductible Amount: \$ _____ Deductible. Met: \$ _____

Subscriber's Name: _____ Relationship: Spouse Father Mother Other _____

Subscriber's SS#: _____-____-____ Subscriber's Date of Birth: __/__/____ Employer: _____

ABOUT YOUR COMPLAINT

Please describe your current complaint and how the problem started: _____

Date of ONSET: _____

Do you have these symptoms today? Yes No How long have you had this condition? _____

Please Rate your Pain by Circling a Number:

No Pain Moderate Pain Unbearable Pain

1. Describe your **current** pain/symptoms: Sharp/Stabbing Throbbing Aches Dull Soreness
 Weakness Numbness Shooting Gripping Burning
 Tingling Stiffness Spasm Other: _____
2. How often are your symptoms present?
 Constantly (81-100%) Frequently (51-80%) Occasionally (26-50%) Intermittently (25% or less)
3. Your pains/symptoms are ... Improving Getting Worse No Change Other _____
4. What makes the problem(s) **BETTER**? Nothing Lying Down Walking Standing Sitting
 Movement Exercise Inactivity/Rest Other: _____
5. What makes the problem(s) **WORSE**? Nothing Lying Down Walking Standing Sitting
 Movement Exercise Inactivity/Rest Other: _____
6. Were you treated for this? Yes No Medications Injection Surgery Chiropractic Physical Therapy Acupuncture
Approximate Dates: _____ Describe treatment/medications and the results: _____
7. Are you currently taking any **medications**? Yes No Describe: _____
8. Have you had any **Diagnostic procedures**? Yes No MRI X-Ray CT-Scan Blood Tests Other tests for this condition

9. Can you perform your daily **home** activity? Yes Only Some Yes, only with help Not at all
10. Do you **exercise**? Yes, almost daily Yes, occasionally Not at all
11. Describe your **job requirements**: Mainly sitting Light Manual Labor Heavy Labor Operate Machinery
12. Can you perform your daily **work** activities? Yes, all activities Only some Not at all
13. Describe your **stress level**: None to Mild Moderate Highly stressed Work Home

Patient Name: _____

HEALTH ASSESSMENT – PAST MEDICAL HISTORY

PAST MEDICAL HISTORY

If you are presently experiencing any of the symptoms or conditions listed below, please mark them in **YES** column. If you *ever* had any of the symptoms or conditions listed below in the past, please mark them in the **Past** column. **KNOWLEDGE OF THESE CONDITIONS MAY ASSIST THE DOCTOR IN TYPE OF TREATMENT/THERAPY YOU RECEIVE.**

YES	Past	CONDITION
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain •Right <input type="checkbox"/> Left <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Upper Arm or Elbow R <input type="checkbox"/> L <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Hand Pain •Right <input type="checkbox"/> Left <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Wrist Pain •Right <input type="checkbox"/> Left <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Upper Back Pain
<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Upper Leg or Hip R <input type="checkbox"/> L <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Lower Leg or Knee R <input type="checkbox"/> L <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Ankle or Foot R <input type="checkbox"/> L <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain
<input type="checkbox"/>	<input type="checkbox"/>	Swelling, Stiffness of Joint(s)
<input type="checkbox"/>	<input type="checkbox"/>	Fainting
<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Muscular Incoordination
<input type="checkbox"/>	<input type="checkbox"/>	Tinnitus (Ringing or Noises in Ear)
<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heart Beat
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite
<input type="checkbox"/>	<input type="checkbox"/>	Anorexia
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight Gain <input type="checkbox"/> Loss <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis
<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	Irregular Menstrual Flow
<input type="checkbox"/>	<input type="checkbox"/>	Profuse Menstrual Flow
<input type="checkbox"/>	<input type="checkbox"/>	Breast Soreness <input type="checkbox"/> Lumps <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis
<input type="checkbox"/>	<input type="checkbox"/>	PMS
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control
<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain
<input type="checkbox"/>	<input type="checkbox"/>	Constipation/Irregular Bowel Habits
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in Swallowing
<input type="checkbox"/>	<input type="checkbox"/>	Heartburn/Indigestion
<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/Eczema/Rash

YES	Past	CONDITION
<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Aortic Aneurysm
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Angina
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack Date: _____
<input type="checkbox"/>	<input type="checkbox"/>	Stroke Date: _____
<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Cancer, Explain: _____
<input type="checkbox"/>	<input type="checkbox"/>	Tumor, Explain: _____
<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems
<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorder _____
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema (chronic lung disorders)
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis

YES	Past	CONDITION
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Liver / Gallbladder problems
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorders (by condition)
<input type="checkbox"/>	<input type="checkbox"/>	Colitis
<input type="checkbox"/>	<input type="checkbox"/>	Irritable Colon
<input type="checkbox"/>	<input type="checkbox"/>	HIV / AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

FAMILY HISTORY If a family member has had any of the following, please indicate.

<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	Chronic Back Problems
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Chronic Headaches
<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	Lupus
<input type="checkbox"/>	Lung Problems	<input type="checkbox"/>	Other _____
<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Other _____

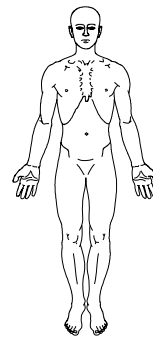
YES	Past	CONDITION
<input type="checkbox"/>	<input type="checkbox"/>	Tobacco
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol
<input type="checkbox"/>	<input type="checkbox"/>	Drug or Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/>	Coffee / Tea / Caffeinated Soft Drinks > Cups/Cans per Day: _____

Yes	No	QUESTION
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a permanent disability rating?
		Location: _____
		Date Rating Received: ___/___/___
		Rating Percentage: _____ %

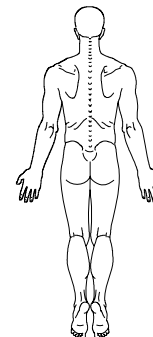
PLEASE MARK ON THE PICTURES BELOW WHERE YOU HAVE PAIN OR OTHER SYMPTOMS. INCLUDE SYMPTOMS OF NUMBNESS, TINGLING, MUSCLE TIGHTNESS, SORENESS, ETC.



RIGHT SIDE



FRONT



BACK



LEFT SIDE

→ Weight _____ pounds Height _____ feet _____ inches

YES	NO	QUESTION
<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy; Number of Births: _____
<input type="checkbox"/>	<input type="checkbox"/>	Birth Control Pills, type: _____
<input type="checkbox"/>	<input type="checkbox"/>	Medications (list here) _____
<input type="checkbox"/>	<input type="checkbox"/>	Hospitalizations/Surgical Procedures: _____
		List/Explain: _____

I certify that the above information is complete and accurate to the best of my knowledge. I further understand that providing incorrect or misleading information may prevent me from getting the best care possible. I agree to notify the doctor immediately whenever I have changes in my health condition, changes in legal representation and health plan coverage in the future.

↙ sign

<p>_____ Patient's or Guardian Signature</p>	<p>_____ Date</p>	<p>_____ I have reviewed the information contained on this form with the patient.</p>
		<p>_____ Provider Initials</p>
		<p>_____ Date</p>



Financial Agreement

We are committed to providing you with the best possible care. The purpose of this agreement is to clarify the financial aspects of your care. This way we can devote our efforts to helping you get the best results in the shortest amount of time. Your clear understanding of our financial policy is important to our professional relationship. We would be pleased to discuss our professional fees with you at any time.

FORMS OF PAYMENT - We accept cash, checks, and most credit cards. Patients are responsible for full payment at the time of service. Any credit arrangements must be pre authorized.

GROUP OR INDIVIDUAL INSURANCE (PPO/HMO/POS Contracts) - Most insurance policies cover chiropractic care, but this office makes no representation that yours does. Insurance policies can differ greatly in terms of deductible and percentage of coverage. As a courtesy to our patients we will bill your insurance directly. The normal office procedure is for the patient to pay any deductible amount at the beginning of care. In all cases, the initial examination must be paid at the time of services. If there is overpayment, we will promptly refund it. After the deductible is met, you are responsible for any percentage/co-payment amounts due. These are due at the time of service.

- Some insurance policies require physician referral. If insurance require pre-authorization, we may be able to get your care pre-authorized. However, you are responsible for necessary but unauthorized services.
- If we are a participating provider with your insurance, we will handle your treatment claims according to our agreement with your insurance company.
- If your insurance requires reports to document your treatment and progress, your signature below authorizes the release of medical information necessary to process your claim.
- Any claims over 60 days will become the patient's responsibility. Please contact your insurance company on those claims and we may also assist you.
- Overdue accounts may be subject to an interest charge after 90 days and may be subject to collection attempts.
- Monthly or periodic statements are sent to inform you of your account activity.
- All patients are responsible for deductibles, co-payments, denied charges or any service not covered by your insurance.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS - Please present your auto and/or health insurance information as soon as possible. If an attorney is handling your case, please notify us of the attorney's name, address and phone number within 24 hours. Although you are ultimately responsible for your bill for medical services received, our office will in most cases will wait for settlement to be paid as long as you are an active patient. If you suspend or terminate care, any fees for services are due immediately. Some therapies, supplies, or diagnostic exams may not be authorized by the representing attorney. In this case, you may be required to pay the necessary fees. Also, most personal health insurance policies may not cover medical expenses incurred due to auto accidents.

- **MadPay or Medical:** In California, if your own auto insurance covers Medical/MedPay, we may be able to bill your insurance for medical expenses. Please note that in most cases, MedPay is NOT included in "full coverage" policies, unless you opt-in and pay for it. MedPay applies to you and your family, and any passengers in the vehicle at the time of the accident, regardless of who is at fault in the accident. MedPay covers practically all forms of medical care including the reimbursement for out-pocket costs reasonably related to the auto accident up to the policy limits. If you were a passenger in someone else's vehicle, please ask the owner/policy holder of that vehicle to initiate a claim on your behalf. Please inform our office if you have other expenses claimed with the MedPay coverage. Furthermore, please understand some MedPay policies require we bill your personal health insurance and MedPay will cover only the unpaid excess. Therefore, we require your health insurance and auto insurance policy information, i.e. Insurance Company, Claim Number, Adjuster Name, Phone and Billing Address prior to commencing treatments.
- **PIP:** If you were a passenger in another vehicle, and if you own a car with PIP (Personal Injury Protection) coverage, you can claim your medical bills.
- **3rd Party:** If another vehicle has caused the accident, we will first bill your automobile MedPay or PIP policy for payment PRIOR to submitting a claim to the insurance carrier of the party at fault. If we rely solely on 3rd party settlement for payment, please understand that the insurance carrier will pay you directly upon settlement. By signing this form, you agree to pay your balance in full within 3 days of receiving your settlement. Furthermore, we will require you to sign authorization for our office to directly contact and receive claim and settlement information from the 3rd party insurance carrier prior to rendering you with billing invoices and medical reports or documents.
- **Attorney Liens:** Please notify us of the attorney's name, address and phone number within 24 hours. Our policy is to have you and your attorney sign a Doctor's Lien to help guarantee direct payment to our office upon the settlement of your case. We reserve the right to first submit all charges to your private and/or auto insurance policy for payment. This office does not discount or reduce the amount of your balance based upon the outcome of your settlement.

WORKER'S COMPENSATION - Worker's Compensation pays for Chiropractic care for covered services contingent on medical provider network participation. While the doctor participates with many insurance carriers, there are countless other carriers that he may not be participating with. You may inquire as to the doctor participation prior to receiving care. Your employer's workers compensation insurance carrier, by law, is financially responsible for your medical bills. In California, chiropractic care is usually limited to maximum of 24 treatment visits upon authorization by the insurance. Upon being released from care, a three-month time period is allowed for settlement of your claim. If settlement has not been reached within this time period, or if you have suspended or terminated your care without your doctor's approval, payment for services is due immediately. If upon investigation, it is determined by your employer or their workers compensation carrier that your injuries are industrially caused or related, you will be personally responsible for the payment of all treatment charges previously incurred, as well as all future charges.

- **Notification of Employer:** When you have a work-related injury or illness, the law requires you notify your employer immediately, and no later than 30 days from knowledge of your injury. If you do not report your injury as required, you may lose your benefits and you may be responsible for treatments.
- **Pre-existing Condition or Symptom:** If it has been determined, upon your evaluation, that you are currently experiencing symptoms or problems that are unrelated to your industrial injury, you will be personally responsible for payment of those treatment charges, as your employer or their workers compensation carrier is not be responsible for treatment to a non-industrial condition. We will be happy to file a separate claim to your private or group health insurance policy, if applicable.
- If you choose not to receive the care that is recommended for the treatment of your condition, we will notify your workers compensation insurance and your case will be closed.

MEDICARE (Part B = Medical)

- Please be aware that you may have an unmet annual deductible. The Medicare deductible amount may change from year to year.
- Medicare only allows payment for **Manual Manipulation** of the spine for the treatment to **correct spinal Subluxation** (spinal miss-alignment).
- **Medicare does not cover charges for the initial examination, x-rays and physical therapy modalities.**
- Medicare may deem your treatments "**medically un-necessary**" and therefore deny payments. You may be responsible for the denied charges.

PAYMENT PLANS - Payment plans may be arranged on a one-to-one basis during financial difficulties prior to treatment.

BILLING - Any outstanding balances are billed monthly and considered past due 15 days after the invoice date or when special arrangements are not met. Return checks are subject to a \$35.00 fee. A balance older than 30 days will accrue interest charges of 1.5% per month, plus any legal or collection fees. Please be aware that your unpaid balance may be subject to be turned over to a collections agency.

PATIENT AGREEMENT - I have read and understand the above financial policy and I agree to comply under the terms described.

Patient Name

Patient/Responsible Party Signature

Date

Dr. Dilojan Abayaratna, D.C.
Clinic Representative

Date



Arbitration Agreement

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Patient Name Patient/Representative Signature Date _____
Indicate relationship if signing for patient

Dr. Dilojan Abayaratna, D.C.
Clinic Representative Name Clinic Representative Signature Date

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

Patient Name _____

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic 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 doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand and I am being informed that, as in the practice of medicine, in this case with chiropractic care and like all other health modalities, results or outcomes are not guaranteed, and there is no promise of cure.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains or joint injuries. In isolated cases, there may be underlying physical defects, deformities or pathologies such as weak bones due to osteoporosis. When osteoporosis, degenerative disk, or other abnormality is detected, this doctor will proceed with extra caution. I also understand strokes involving chiropractic adjustments are rare, and according to recent statistics, about once in one million to once in ten million cases. Physiotherapy procedures in rare cases may cause minor burns and subsequent increase of pain and blistering. This should be reported to the doctor. Furthermore, I may experience soreness following the first few treatments; there is a rare possibility of having temporary symptoms like dizziness and nausea. I do not expect the doctor to be able to anticipate and explain all 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, that are in my best interests.

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

Reasonable alternatives to these procedures, which may or may not be applicable to me at this time, have been explained to me including rest, home application of therapy, exercises, other medical referral for consultations and possible surgery.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction prior to my signing this consent form. I further understand that I may receive treatment procedures rendered by an employee or a person trained and designated by the doctor, in the event where he is not available to render care to me. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I have made my decision voluntarily and freely and attest to my consent for treatment with my signature below.

Patient's Signature (Or Guardian/Parent/Representativ

Date

Please sign, date and promptly return one copy to the front desk.

