**APPLICATION FOR CARE AT MANGI Chiropractic & Acupuncture, Inc.**

 **TODAY’S DATE:**

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Birth Date**: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ **Age**: \_\_\_\_\_\_\_ 🞏 Male 🞏 Female

**Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State**: \_\_\_\_\_ **Zip**: \_\_\_\_\_\_\_\_\_\_\_\_

**E-mail Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Home Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Marital** **Status**: **❑** Single **❑** Married **Do you have Insurance**: **❑** Yes **❑** No ***Please present insurance card(s) to the front desk.***

**Social Security #**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Number of children and Ages**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employer**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Occupation**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Spouse’s Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Spouse’s Employer**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Whom may we thank for referring you to this office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**Name of Emergency Contact**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Emergency Contact #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HISTORY of COMPLAINT**

Please identify the condition(s) that brought you to this office: Complaint: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Location:** | **Onset:** | **What Makes It Worse?** | **Type of pain:** | **Pain Radiating Into:** | **Severity of Pain 1-10****(10 Worst)** | **Time Out of a Week** |
| Left  | Today | Everything  | Aching | Left Head | 1 | 10% |
| Right | This Week | Nothing  | Burning | Right Shoulder | 2 | 20% |
| Both | This Month  | Lifting | Deep | Front Arm | 3 | 30% |
| Front  | This Year | Working  | Dull | Back Hand | 4 | 40% |
| Back |  | Sitting | Sharp |  Ribs | 5 | 50% |
|  |  | Bending | Soreness |  Buttocks | 6 | 60% |
|  |  | Standing | Stabbing |  Hip | 7 | 70% |
|  |  | Sneezing | Stiffness |  Leg | 8 | 80% |
|  |  | Coughing | Tenderness |  Foot | 9 | 90% |
|  |  |  | Tingling |  | 10 | 100% |

When did the problem(s) begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When is the problem at its worst? 🞏 AM 🞏 PM 🞏 mid-day 🞏 late PM

How long does it last? 🞏 It is constant **OR** 🞏 I experience it on and off during the day **OR** 🞏 It comes and goes throughout the week

**How did the injury happen? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**C**ondition(s) ever been treated by anyone in the past? 🞏No 🞏 Yes **If yes,** when: \_\_\_\_\_\_\_\_ by whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long were you under care: \_\_\_\_\_\_\_\_\_\_\_\_ What were the results? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Previous Chiropractor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **🞏 N/A**

**\*PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:

 **R = R**adiating **B** **= B**urning **D =** **D**ull **A =** Aching **N = N**umbness **S =** **S**harp/ **S**tabbing **T= T**ingling

What relieves your symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes them feel worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is your problem the result of ANY type of accident? 🞏 Yes, 🞏 No**

Identify any other injury(s) to your spine, minor or major, that the doctor

should know about:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST HISTORY**

Have you suffered with any of this or a similar problem in the past? ❑ No ❑ Yes **If yes** how many times? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_

When was the last episode? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How did the injury happen? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other forms of treatment tried: 🞏 No 🞏 Yes **If yes,** please state **what** type of treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, and whoprovided it: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **How long ago? \_\_\_\_\_\_\_**What were the results. 🞏 Favorable 🞏 Unfavorable🡪 please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any medications you are currently taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mark **X** for **present** conditions, **O** for **past** conditions**:**

|  |  |  |  |
| --- | --- | --- | --- |
| \_\_\_ Neck Pain | \_\_\_ Back Curvature | \_\_\_ Sinus Problems | \_\_\_ Double/ Blurred Vision |
| \_\_\_ Numb/ Tingle Pain arms, hands, fingers | \_\_\_ Arthritis | \_\_\_ Trouble Sleeping | \_\_\_ Pain w/ Cough/ Sneeze |
| \_\_\_ Upper / Mid / Low Back Pain | \_\_\_ Diabetes | \_\_\_ Ringing in Ears | \_\_\_ Foot Trouble |
| \_\_\_ ADD / ADHD / Autism | \_\_\_ Swollen/ Painful Joints | \_\_\_ Hearing Loss | \_\_\_ Chest Pain |
| \_\_\_ Numb/ Tingle Pain legs, feet, toes | \_\_\_ Frequent Colds/ Flu | \_\_\_ Mood Changes / PMS | \_\_\_ Heart Problem/Disease |
| \_\_\_ Headache | \_\_\_ Convulsions/ Epilepsy | \_\_\_ Eating Disorder | \_\_\_ Menstrual Problems |
| \_\_\_ Hip Pain | \_\_\_ Cancer | \_\_\_ Shoulder Pain | \_\_\_ Stroke |
| \_\_\_ Difficulty standing, walking, orSitting | \_\_\_ High / Low Blood Pressure | \_\_\_ Dizziness / Loss of Balance / Fainting | \_\_\_ Lung / Breathing Problems |
| \_\_\_ Difficulty exercising/daily activities | \_\_\_ Depression | \_\_\_ Jaw Pain, TMJ | \_\_\_ Varicose Veins |
| \_\_\_ Fractured Bones | \_\_\_ Irritable | \_\_\_ Ulcers | \_\_\_ Liver Trouble |
| \_\_\_ Other Accidents/ Falls | \_\_\_ Anemia | \_\_\_ Kidney Trouble | \_\_\_ Gall Bladder Trouble |
| \_\_\_ Heartburn | \_\_\_ Tremors | \_\_\_ Ear Infection | \_\_\_ Digestive Problems |
| \_\_\_ Prostate Problems | \_\_\_ Allergies / Asthma | \_\_\_ Surgeries | \_\_\_ Menopausal Problems |
| \_\_\_ Bed Wetting | ­\_\_\_ Hepatitis (A, B, C) | \_\_\_ Skin Problems | \_\_\_ AIDS/ HIV |

**SOCIAL HISTORY**

**1. Smoking**: ❑cigars ❑ pipe ❑ cigarettes 🡪 How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

**2. Alcoholic** **Beverage**: consumption occurs 🡪 ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

**3. Recreational Drug use**: 🡪 ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

**FAMILY HISTORY**:

**1.** Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes

 **If yes whom**: ❑ grandmother ❑ grandfather ❑ mother ❑ father ❑ sister’s ❑ brother’s ❑ son(s) ❑ daughter(s)

 Have they ever been treated for their condition? ❑ No ❑ Yes ❑ I don’t know

I hereby authorize payment to be made directly to MANGI Chiropractic & Acupuncture, Inc., for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to MANGI Chiropractic & Acupuncture, Inc., for any and all services I receive at this office. I understand MANGI Chiropractic & Acupuncture, Inc. will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount to be paid directly to MANGI Chiropractic & Acupuncture, Inc. will be credited to my account upon receipt. I give MANGI Chiropractic & Acupuncture, Inc. and its representatives permission to communicate to me via the contact information above. For any balance I have incurred at this office, I agree to have any credit card on file charged for remaining balance due. I agree to pay all court cost/attorney fees/collection fees/etc. and monthly late fees should my account become delinquent and forwarded to a legal representative.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

 **Patient or Authorized Person’s Signature Date**

MANGI Chiropractic & Acupuncture, Inc. HIPAA

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation (**PHI**). In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you.

**PERMITTED DISCLOSURES:**

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient’s death.
10. Telephone calls, emails, & appointment reminders -**we may call your home and leave messages/send text messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

**YOUR RIGHTS:**

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive “Detailed” Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

**PHI Disclosures to Family and/or Friends:**

Do you want to designate a family member or other individual with whom the provider may discuss your medical condition? If Yes, Whom? Please list below:

***\*I give permission for my PHI to be disclosed for purposes of communicating results, findings, and care to persons listed below. Patient/Representative may revoke or modify this specific authorization and that revocation or modification MUST be in writing.\****

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_RELATIONSHIP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CONTACT #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME:\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_\_\_\_\_\_\_RELATIONSHIP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CONTACT #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this ‘Notice of Privacy Practice” at any time in the future and will make the new provisions effective for all information that it maintains past and present.**

**I am aware that a more comprehensive version of this “Notice” is available to me should I request one. At this time, I do not have any questions regarding my rights or any of the information I have received. By signing below, I have read, understand, and agree to all above information herein.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature Date**

**Welcome to MANGI Chiropractic & Acupuncture, Inc.!**

As a potential new patient, we feel it is important that you understand our office policies regarding how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return. We believe it is in everyone’s best interests to provide potential new patients as much information as possible about how the doctors at this office practice chiropractic so that an informed decision can be made as to whether they wish to become a patient.

Over time, individuals who are accepted as patients at this office, gain a greater understanding as to the purpose of chiropractic. This knowledge and awareness reaps a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about.

**PATIENT PRIVACY –** Since the majority of patient care takes place in an open bay area it is important to understand that any conversations you have with the doctor can be overheard by other patients. In order to maintain patient privacy it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter you wish to discuss please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance. **\_\_\_\_\_\_ Initials**

**YOUR CARE** - When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Care at **MANGI Chiropractic & Acupuncture, Inc.** is rendered primarily to minimize and reduce subluxations, which are a major interference to the expression of the body’s innate wisdom. The doctors use **1) Chiropractic Adjustments OR 2) a myriad** of techniques to accomplish this goal, including but not limited to **Acupuncture, Nutritional Hair Analysis, Rehabilitative Exercise, and Massage Therapy**. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through two distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving you overall health. **\_\_\_\_\_\_ Initials**

**FIRST THINGS FIRST**- Prior to receiving chiropractic or acupuncture care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so t**h**at you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do in addition to being adjusted to maintain their health for a lifetime. **\_\_\_\_\_\_ Initials**

**PATIENT’S REPORT OF FINDINGS** – To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your first adjustment, you may be scheduled for a ‘Doctors Report of Findings’. The information you receive at this appointment will be both informative and clinically relevant to your case, therefore attendance is required for individuals who wish to become new patients of this practice. Because the results of your x-rays and all examinations as well as the doctors’ recommendations for care, will be discussed at that time, we strongly urge new patients to invite their spouse or significant other to attend. We know from experience that when a patient’s family understands the goals and objectives of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options. **\_\_\_\_\_\_ Initials**

*By initialing each paragraph I fully understand this ‘Notice’.* *I further acknowledge that any concerns regarding these ‘Policies ’as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.*

AUTHORIZATION FOR CASE REVIEW

Here at **MANGI Chiropractic & Acupuncture, Inc.** we take a holistic approach to each patient’s health care. It is our desire that each patient receive an optimum health care evaluation. This means that it may be necessary to have another specialist, through consultation with the doctor, review your case for their opinion. This may be in the form of previous records from other providers or current findings in our office. Your signature below acts as a release to obtain those records. In this way, we can deliver high quality care to you, our patient.

**THE PURPOSE OF THIS OFFICE IS TO SUPPORT EACH INDIVIDUAL IN ACHIEVING THEIR OPTIMUM HEALTH AND TO EDUCATE THEM SO THAT THEY MAY UNDERSTAND HEALTH AND CHIROPRACTIC AND IN TURN EDUCATE OTHERS.**

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I am responsible for knowing my insurance coverage. The doctor’s office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the doctor’s office will be credited to my account upon receipt. I, the undersigned, certify that in the event I (or my dependent) have insurance coverage I assign directly to

Dr. Andrea Mangi-Bassett/MANGI Chiropractic & Acupuncture, Inc., all insurance benefits. However, I clearly understand and agree that all services (from first/past treatment(s) to present) rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and/or treatment, any and all fees for services rendered me will be immediately due and payable and I agree that any credit card on file will be charged for the full amount due plus late fees if they apply. A delinquent account is subject to bear interest at the maximum legal rate and a set late fee ($35.00 per month). Should the account become delinquent and be referred to a collection agency or legal representative, I shall pay all reasonable associated expenses, including but not limited to court fees, attorney fees, collections/collection agency fees etc. A $35.00 rescheduling fee for missed appointments will be added to my account unless I have contacted the office at least 24 hours before my scheduled appointment.

***I hereby authorize the Doctor/Therapist to treat my condition as deemed appropriate. I also acknowledge that services provided are billed per each service i.e. spinal adjustment, extremity adjustment, traction table, electrical stimulation, x-rays; etc. are separate codes with separate dollar amounts and are billed to insurance according to their insurance codes. If certain therapies are not wanted after doctor deems them necessary for expedited recovery, it is patient’s responsibility to inform doctor of therapies that are unwanted.*** It is understood and agreed the amount paid to the Doctor/Therapist for diagnostic images, is for examination of images only and all negatives will remain the property of this office, being on file where they may be reviewed at any time while a patient with this office. The Doctor/Therapist will not be held responsible for any pre-existing medically diagnosed conditions, not for any medical diagnoses. This agreement does not expire.

Name (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_