



## NEW ANIMAL PATIENT INTAKE FORM

Animal's Name: \_\_\_\_\_ Breed: \_\_\_\_\_

Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Weight: \_\_\_\_\_

Spayed/Neutered?

- Yes
- No

Health Concerns: \_\_\_\_\_

Past surgeries (if any): \_\_\_\_\_

Medications (Past & Current): \_\_\_\_\_

Primary Veterinarian: \_\_\_\_\_

Has he/she ever received chiropractic care before?

- Yes
- No

If yes, by who? \_\_\_\_\_

Owner's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_

How did you hear about Williamson Chiropractic?

Name: \_\_\_\_\_

- Family
- Friend
- Co-Worker
- Doctor
- Social Media
- Google/Online
- Other \_\_\_\_\_

Email: \_\_\_\_\_

\*We do not sell our email list.

- I would like to receive emails **regarding appointment reminders, office closures, holiday hours, promotions, discounts, health & wellness information, monthly newsletter, etc.**
- I would only like to receive emails **regarding appointment reminders, office closures and holiday hours.**

# WILLIAMSON CHIROPRACTIC SERVICES, LLC

## Terms of Acceptance

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Before Williamson Chiropractic begins any health care services, we require that you read the below information and sign this form stating that you fully understand the following statements. If you do not sign this form, Dr. Williamson reserves the right to refuse patient care.

**AUTHORIZATION:** By signing this form, you hereby authorize this office/provider to complete an examination and consultation on the above-mentioned patient.

**ACKNOWLEDGEMENT OF ASSIGNED BENEFITS:** By signing below, you have acknowledged that you are fully responsible for all services rendered.

**ACKNOWLEDGEMENT OF CANCELLATION/NO SHOW FEE:** By signing below, you have acknowledged that you will be charged a cancellation fee of \$20.00 if cancelled within less than 24 hours of your scheduled appointment. By signing below, you also acknowledge that if you do not show up to a scheduled appointment and have made no attempt to cancel, you will be charged a \$20.00 no show fee.

**ACKNOWLEDGEMENT OF VETERINARY REFERRAL:** By signing below, you have acknowledged that you have received a signed referral from the patient's treating veterinarian and presented it to Dr. Williamson for animal chiropractic care upon the patient's first visit.

**ACKNOWLEDGMENT OF TREATMENT PLAN:** By signing below, you have acknowledged that, if accepted for care, you may be presented with a chiropractic treatment plan resulting in one or more of the following services: chiropractic adjustments, examinations, and supportive therapies and procedures.

**ACKNOWLEDGEMENT:** By signing below, you have acknowledged that you understand and agree with the policies and procedures outlined in this TERMS OF ACCEPTANCE form. By signing below, you acknowledge and certify that all information given to the office/provider in the INTAKE forms are true and accurate to the best of your knowledge.

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

Date: \_\_\_\_\_

**WILLIAMSON CHIROPRACTIC SERVICES, LLC**  
**Consent for Chiropractic Care**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**By reading below, I have been made aware:**

1. The process of delivering a "Chiropractic Adjustment" (manipulation) may be performed manually by hand or with a hand-held instrument (activator) to vertebra(e) of the spine and/or associated structures which may occasionally result in an audible pop or click sound;
2. That on occasion, some temporary soreness and/or stiffness may occur; less frequently aggravation of presenting symptoms or initiation of new symptoms; rarely bruising, swelling and even more rare, separation/fracture; and extremely rare, nerve or vascular injury may occur in conjunction with the process of a Chiropractic Adjustment;
3. That the chiropractor has made no guarantee of a positive outcome from treatment.

**Additionally:**

1. I have been afforded ample opportunity for questions and answers.

**THEREFORE, BY SIGNING BELOW:**

*I consent* to the performance of the diagnostic and therapeutic procedures performed by Dr. Williamson.

*I consent* to the performance of other diagnostic and therapeutic procedures in the future that may be deemed reasonable and necessary by Dr. Williamson.

*I understand* the risks and benefits associated with chiropractic care and am willing to accept care for my animal on this basis.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_