**LeBlanc Chiropractic New Patient Packet**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Patient #**\_\_\_\_\_\_\_\_\_\_\_ Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN:\_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_Race: \_\_\_\_\_\_\_\_\_\_\_ E-mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Office Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital: M S W D (circle one) How many children? \_\_\_\_\_\_\_\_\_\_\_

Spouse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Nearest Relative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

How were you referred to our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Medical Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Clinic Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? Yes No

**PAST MEDICAL HISTORY**

Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that apply to you)

|  |  |  |  |
| --- | --- | --- | --- |
| \_\_Broken or Fractured Bones | \_\_Osteoarthritis \_\_Eating Disorder | \_\_Dizziness | \_\_Circulatory |
| \_\_Circulatory Problems | \_\_Epilepsy \_\_Alcoholism | \_\_Backaches | \_\_Hypertension |
| \_\_Arthritis | \_\_Pace Maker \_\_Drug Addiction | \_\_Heart Trouble | \_\_Neuritis |
| \_\_Rheumatoid Arthritis | \_\_Strokes \_\_HIV Positive | \_\_Diabetes | \_\_Anemia |
| \_\_A Congenital Disease | \_\_Seizures/Convulsions\_\_Gall Bladder | \_\_Sinus Trouble | \_\_Hernia |
| \_\_Excessive Bleeding | \_\_Ruptures \_\_Depression | \_\_Headaches | \_\_Cancer |
| \_\_High/Low Blood Pressure | \_\_Coughing Blood \_\_Ulcers | \_\_Nervousness |  |
| \_\_Numbness | \_\_Asthma \_\_ Rheumatic Fever | \_\_Digestive Disorders |  |

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has a physician treated you for any health condition in the last year? Yes No (circle one)

If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What medications or drugs are you taking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any allergies to any medications? Yes No (circle one) describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any allergies of any kind? Yes No (circle one) describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any other health problems you have, no matter how insignificant they may be:

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

**SOCIAL HISTORY:**

Do you drink alcoholic beverages? \_\_\_\_\_\_\_\_ If so, how much per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use any tobacco products? \_\_\_\_\_\_\_\_Do you smoke? \_\_\_\_\_\_\_ If so, packs per day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take vitamin supplements? \_\_\_\_\_\_\_\_ If so, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you consume caffeine? \_\_\_\_\_\_\_\_ If so, how much per day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you exercise? \_\_\_\_\_\_\_\_ If yes, what is the frequency and type of exercise?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What are your hobbies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What percentage of time during the day (at home or at your job away from home) do you spend:

Lifting \_\_\_\_\_% Sitting \_\_\_\_\_% Bending \_\_\_\_\_% Working at a computer\_\_\_\_\_%

**FAMILY HISTORY**: Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Father:** living\_\_\_\_ deceased\_\_\_\_ (check one) Current age if still living: \_\_\_\_\_\_

Cause of death and age at death if deceased: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mother:** living\_\_\_\_ deceased\_\_\_\_ (check one) Current age if still living: \_\_\_\_\_\_

Cause of death and age at death if deceased: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Check if applicable to you: \_\_\_\_ As an adopted child, little is known of my birth parents or family.*

Do you have any family members who suffer from the same condition you do? If so, please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAMILY DISEASES (if applicable, indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

|  |  |  |  |
| --- | --- | --- | --- |
| Autoimmune | \_\_\_\_ | Cancer \_\_\_\_ | Mental Illness \_\_\_\_ |
| Diabetes | \_\_\_\_ | Asthma \_\_\_\_ | Heart Disease \_\_\_\_ |
| Stroke | \_\_\_\_ | Kidney Disease \_\_\_\_ | Lung Disease \_\_\_\_ |
| Arthritis | \_\_\_\_ | Liver Disease \_\_\_\_ | Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**HISTORY OF PRESENT ILLNESS:**

1. Chief Complaint / Purpose of this appointment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Date symptoms appeared or accident happened: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. If this is a recurrence, when was the first time you noticed this problem?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did it originally occur?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Has it become worse recently? Yes No Same Better Gradually Worse (circle one)

If yes, when and how? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Is this due to: Auto\_\_\_\_ Work\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. What makes the problem worse? Standing Sitting Lying Bending Lifting Twisting (circle one)

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Is there anything you can do to relieve the problem? Yes No (circle one). If yes, describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

If no, what have you tried to do that has not helped? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Describe the pain: Sharp Dull Numbness Tingling Aching Burning Stabbing (circle one)

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

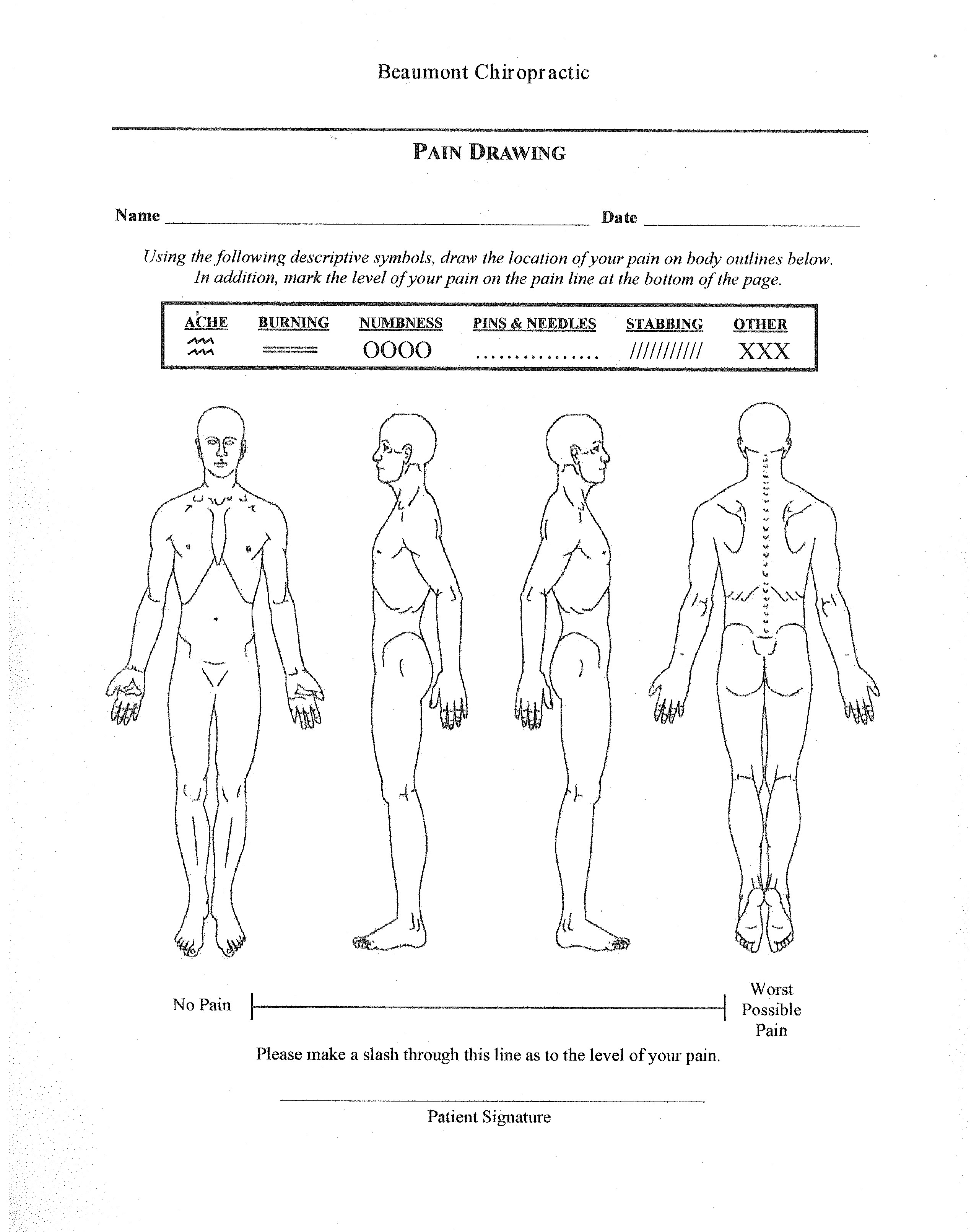
1. How frequent is the condition? Constant Daily Intermittent Night Only (circle one)

How long does it last? All Day Few Hours Minutes (circle one)

1. Are there any other conditions or symptoms that may be related to your major symptom? Yes No (circle one) If yes, describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are there other unrelated health problems? Yes No (circle one) If yes, describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Days lost from work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last physical examination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Have you had any broken bones? Yes No (circle one). If yes, please list and give dates \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. **WOMEN ONLY:** Are you pregnant or is there any possibility you may be pregnant?Yes \_\_ No \_\_ Uncertain \_\_

Doctor’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LeBlanc Chiropractic**



**Financial Policy of LeBlanc Chiropractic LLC**

Our recommendations are based on a desire to see you get well and stay well. We ask that you read and understand our policy as it applies to your particular situation.

We currently do not take insurance and we request that 100% of each visit be paid at the time of the visit unless other arrangements have been made. We are happy to accept cash, check, or credit card.

Schedule of Fees:

New Patient w/o X-Ray: $50.00 Re-Exam: $30.00

1-2 level adjustment: $35.00 Update Exam $40.00

3 level adjustment: $45.00 STEM $15.00

Infant treatment : $50.00 Heat/Ice $2.00

Acupuncture: $40.00

## Group or Individual Insurance

Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers Chiropractic, although most policies do provide coverage. We are more than happy to provide you with a super bill that you can submit to your insurance for reimbursement.

## Worker’s Compensation

If you are injured on the job, your care should be paid for under your employer’s Worker’s Compensation insurance; however, we DO NOT accept Worker’s Compensation.

## Personal Injury or Automobile Accidents

We do not accept Personal Injury cases or LOP’s from attorneys.

## Medicare

We currently do not take Medicare but are working on the ability to in the near future. Once we are able to accept assignment from Medicare, our policy will be as follows: The check is usually sent directly to our office in payment of services that Medicare will cover which for Chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. If you do not have secondary coverage, you are required to pay the deductible and the remaining 20% as well as any non-covered services. All other services we provide are NONCOVERED. These services include, but are not limited to, x-rays, examinations, therapies, and supplies. Medicare patients are fully responsible for charges of non-covered services. Our office completes and files the forms for Medicare at no charge.

I have read and understand the payment policy of LeBlanc Chiropractic LLC. I understand that my insurance is an arrangement between myself and my insurance company, NOT between LeBlanc Chiropractic LLC and my insurance company.

I assign my right to receive payment of authorized Medicare benefits to LeBlanc Chiropractic. I request that payment of authorized benefits be made on my behalf to LeBlanc Chiropractic for any services furnished to the patient listed below by LeBlanc Chiropractic physicians and health care providers. I authorize LeBlanc Chiropractic to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided.

I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by Dr. LeBlanc that fees will be due and payable immediately.

Patient/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Patient Health Information Consent Form (HIPAA)

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations, we must require you to read and sign this

consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage

you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Consent to Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and, if necessary, diagnostic x-rays on myself (or on the patient named below, for whom I am legally responsible) by the Chiropractor and/or anyone working in this office authorized by the Chiropractor. I further understand that such chiropractic services may be performed by the Chiropractor and/or other licensed Chiropractors who may treat me now or in the future at this office. I will have an opportunity to discuss with **Dr. Jay LeBlanc** and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the Chiropractor to be able to anticipate and explain all risks and complications. Further, I wish to rely on the Chiropractor to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my Chiropractor. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the patient and/or the patient’s representative, if necessary, (e.g. if the patient is a minor or is physically or mentally incapacitated)

Patient/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



# Office Policies

1. You should be aware that the capabilities of many modern cell phones or mobile devices, such as photo, audio or video recording may make our patients uncomfortable and may infringe upon their rights to confidentiality. Please avoid use of your cell phone or other mobile device in the presence of a patient, or around their protected health information. We ask that you mute, silence, or turn off your cell phone while in our office.

1. We schedule our appointments so that each patient receives the right amount of time to be seen by our staff. That’s why it is very important that patients keep their scheduled appointment and arrive on time.

As a courtesy, and to help patients remember their scheduled appointments, LeBlanc Chiropractic sends text message reminders in advance of the appointment time. Should you need to cancel your appointment please call the office at 409-755-6565.

We understand that patients sometimes need to reschedule appointments. Scheduled appointments must be cancelled or rescheduled prior to the scheduled appointment time. Any patient who fails to arrive for a scheduled appointment without canceling or rescheduling the appointment is considered a “no-show”.

If a patient does not cancel or reschedule with at least 24 hours’ notice, we will assess a $35 “No-Show” service charge to their account. After three consecutive no-shows to appointments, our office will remove remaining appointments from the schedule.

Our goal is to offer the best possible chiropractic care with personal care. We hope you understand our decision and look forward to seeing you at your next appointment.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_