SAUNDERS COUNTY CHIROPRACTIC & ACUPUNCTURE, PC

Dr. Paul Sutton/Dr. Keith Chvatal
260 W. 6th St. Ste 1
Wahoo, NE 68066

Confidential Patient Information

Today's Date: _____/_____/_____

Patient's Full Name: _____

Date of Birth: _____/_____/_____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Email: _____

Current Complaint: _____

Previous Chiropractic/ Massage Care: □Yes □No If yes, for what problem:

_____

Is today's visit due to a Work-Related Injury? □Yes □No
Date of Injury: _____

Is today's visit due to an Auto Accident? □Yes □No
Date of Injury: _____

How did you hear about us? _____

Emergency Contact: _____ Relationship: _____

Phone: _____

SAUNDERS COUNTY CHIROPRACTIC & ACUPUNCTURE, PC

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical or emotional condition, health history, or billing and payment history to any insurance company, attorney, or adjuster for the purpose of any claim for reimbursement of charges incurred by me.

2. I authorize my attorney and/or any insurance company to make direct payment to you of settlement proceeds.

3. I hereby assign and transfer to you the cause of action that exists in my favor against any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your service. I authorize you to prosecute said action either in my name. I further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance companies, whether it be all or part of what was due, I personally owe to you.

4. I further understand that this Authorization and Assignment is irrevocable until all moneys owed to Saunders County Chiropractic & Acupuncture, PC are paid in full.

The nature of the chiropractic adjustment.

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement. As part of the analysis, examination, and treatment, you are consenting to the following procedures: Spinal manipulative therapy, acupuncture, palpation, vital signs, range of motion testing, orthopedic testing, basic neurological, muscle strength testing, postural analysis testing.

The risks inherent in chiropractic adjustment, massage and/or acupuncture.

As with any healthcare procedure, there are certain complications which may arise during chiropractic, massage or acupuncture treatment. These complications include but are not limited to: fractures, bruising, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring: Fractures are rare occurrences and generally result from some underlying weakness of the bone. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with my health professional and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: ____/____/____

_____ _____

Patient Name Print Patient Signature

SAUNDERS COUNTY
CHIROPRACTIC
& ACUPUNCTURE, PC

Name:

Date: