PATIENT INTAKE FORM

Date:_____

PATIENT INFORMATION

Name: (Last, First, MI) _____Preferred Name:_____

Date of Birth:_____

Address:_____City:_____Zip:_____

Home Phone:_____Cell Phone:_____

Work Phone:_____

Occupation:_____Employer:_____

Email:_____

Who Referred You:_____

EMERGENCY CONTACT INFORMATION

Name:_____Phone Number:_____

Relationship to Patient:_____

Patient Name:_____D.O.B_____Date:_____

Before Atlas Chiropractic & Acupuncture begins any health care operations, we require you to read and sign this form stating that you understand and agree to the below information. If you refuse to sign this form, the doctor reserves the right to ref use care.

AUTHORIZATION: By signing below, you authorize Atlas Chiropractic & Acupuncture to complete a consultation, examination and treatment on the above.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: We are very concerned with protecting your personal health information. There may be times our office may need to contact you regarding office matters. By signing below, you have authorized this office to contact you for office related matters in the following manner: phone-work-home or cell, email and regular mail. Messages may be left on an answering machine/voicemail, or with the person answering your phone-home-work-cell. Also, in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA), updated September 23, 2013, this office obliges to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient. By signing below, you have acknowledged that you have been offered a copy of this document.

PERMISSION FOR EMAIL/TEXT COMMUNICATION: By signing below, you allow Atlas Chiropractic & Acupuncture to contact you via text and/or email messages regarding missed appointments, office announcements and other such matters.

ACKNOWLEDGEMENT OF TREATMENT PLAN: By signing the below, I acknowledge that, if accepted for care, I may be presented with a treatment plan resulting in one or more of the following services: chiropractic adjustments, examinations, and supportive therapies and procedure.

ACKNOWLEDGEMENT OF MISSED APPOINTMENTS: Missed appointments will be charged to the patient. We ask that if an appointment can not be made due to life circumstances, please call the office to cancel and reschedule for a more convenient time.

ACKNOWLEDGEMENT OF TERMS OF ACCEPTANCE: 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 the information given to the office/provider in the INTAKE FORMS are true and accurate to the best of your knowledge.

Signature of Patient:_____

Signature of Parent/Guardian:_____

CONSENT FOR CHIROPRACTIC/ACUPUNCTURE SERVICES

By reading below, I have been made aware of the following:

1. The process of delivering a chiropractic adjustment/manipulation may be preformed manually to the vertebra(e) of the spine and/or associated structures (legs, arms, ect.)

2. As an addition to the chiropractic adjustment, "supportive therapies and/or procedures" may be applied by the chiropractor or by staff under the chiropractor's direction or supervision incorporating the use of electricity, intersegmental traction, acupuncture, manual therapy, nutritional advice and exercise prescription.

3. 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, even more rare separation/fracture; and extremely rare, nerve or vascular injury may occur in conjunction with the process of a chiropractic adjustment.

4. 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.

I consent to the performance of the diagnostic and therapeutic procedures performed by the doctor and/or staff under the direction and supervision of the office chiropractor involved in my case.

I consent to the performance of other diagnostic and therapeutic procedures in the future that may be deemed reasonable and necessary by the doctor and/or staff under the direction and supervision of the office chiropractor involved in my case.

Patient/Guardian Signature:_____

Patient/Guardian Printed Name:_____