

APPLICATION FOR CARE AT GET MOVING CHIROPRACTIC

Today's Date: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: ____ - ____ - ____ Age: _____ Male Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Home Phone: _____ Mobile Phone: _____

Marital Status: Single Married Do you have Insurance: Yes No Work Phone: _____

Social Security #: _____ Driver's License #: _____

Employer: _____ Occupation: _____

Spouse's Name _____ Spouse's Employer _____

Number of children and Ages: _____

Name & Number of Emergency Contact: _____ Relationship: _____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primarily: _____

Secondarily: _____ Third: _____ Fourth: _____

On a scale of 1 to 10 with 10 being the worst pain and zero being no pain, rate your above complaints by *circling the number*:

Primary or chief complaint is : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Second complaints is : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Third complaint: : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Fourth complaint: : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

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? _____

Condition(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? _____

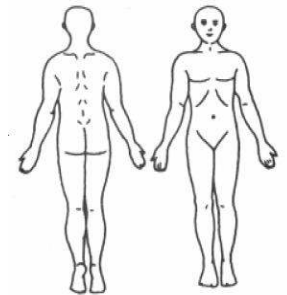
Name of Previous Chiropractor: _____ N/A

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

R = Radiating B = Burning D = Dull A = Aching N = Numbness S = Sharp/ Stabbing T = Tingling

What relieves your symptoms? _____

What makes them feel worse? _____



Doctor only LOCQSMAT:

LIST RESTRICTED ACTIVITY:

CURRENT ACTIVITY LEVEL

USUAL ACTIVITY LEVEL

_____:	_____
_____:	_____
_____:	_____
_____:	_____

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 who provided it: _____ **How long ago?** _____ What were the results. Favorable Unfavorable → please explain. _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the **Past**, **C** for **Currently** have and **N** for **Never have had**:

Broken Bone Dislocations Tumors Rheumatoid Arthritis Fracture Disability Cancer
 Heart Attack Osteoarthritis Diabetes Cerebral Vascular Other serious conditions:

PLEASE identify ALL PAST and any CURRENT conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES	→		
SURGERIES	→		
CHILDHOOD DISEASES	→		
ADULT DISEASES	→		

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
2. **Any other hereditary conditions** the doctor should be aware of. No Yes: _____

Patient or Authorized Person's Signature

____ - ____ - ____
Date Completed

Doctor's Signature

____ - ____ - ____
Date Form Reviewed

Automobile Accident History Form

Patient _____ Age _____ Date _____
 Date and Time of Accident _____
 Location of accident (city, state, street) _____
 Road condition wet dry snow/ice other _____
 Were the police notified of the accident? Yes No Was a report filed? Yes No
 Collision involved: 1 vehicle 2 vehicles 3 + vehicles pedestrian other _____
 Did you go to the hospital afterwards? Yes No Name _____
 How did you get there? _____
 Were you examined by a doctor? Yes No Were x-rays taken? Yes No
 What body parts x-rayed? _____
 What did the Dr. say was wrong? _____
 Treatment/medications given? _____

INDICATE ON THIS DRAWING WHAT HAPPENED
 SKETCH IN THE SCENE OF YOUR ACCIDENT, WRITING IN STREET OR HIGHWAY NAMES

1. Number vehicles (1 for yours) and show direction of travel by an arrow: 1 →
2. Use solid line to show path before accident _____ dotted line after _____
3. Show distance and direction to landmarks; identify landmarks by name/number.
4. Show pedestrian by ○
5. Indicate north by arrow: N ↑

Driver of car _____
 Where were you seated? driver front passenger rear left rear right
 Other occupants in the car and their injuries? _____
 Were you struck from: behind front left side right side other _____
 Were you aware of the collision prior to impact? Yes No
 Did you brace for impact? Yes No
 How far is the head rest or seat back from your head? less than 3" 3 to 6" greater than 6"
 Were you wearing? seatbelt shoulder harness none
 Did the airbag deploy? Yes No
 Year/make/model of car you were in ? _____
 Estimated cost of damage? _____ Was your vehicle drivable? Yes No
 What car parts were damaged? _____
 Was your car moving at the time of collision? Yes No If yes, how fast? _____ Mph
 Were you braking? Yes No If no, was the driver's foot on the brake? Yes No
 Did your body strike anything in the car? _____
 Was your head: pointed straight ahead turned right turned left
 Year/make/model of the other car? _____ Damage: min mod severe
 Was the other vehicle drivable? Yes No
 Was the other car moving at the time of collision? Yes No If yes, of fast? _____ Mph
 If moving, was the other vehicle slowing down gaining speed steady speed
 Describe how the accident happened:

Describe where you felt pain or unusual feelings: (location, type, severity)

a: During the accident: _____

b: Immediately after the accident: _____

c: Later that day/night: (and up to now) _____

Did you lose consciousness (black out)? Yes No If yes, for how long? _____

If no, were you dazed/confused? Yes No

Did you experience a flash of light or explosion in your head? Yes No

Did you receive any injuries/bruises/cuts from the seatbelt or airbag? Yes No

Did you receive any bleeding cuts? Yes No Did you receive any bruises? Yes No

Where? _____

Check the symptoms you have noticed since the accident: (P= pain)

- Headache Ringing in ears Sleeping problems Diarrhea/constipation
- Neck P Loss of smell/taste Numb toes Stomach upset/pain
- Mid back P Loss of memory Numb fingers Shortness of breath
- Low back P Jaw pain Fatigue Pins/needles in arms
- Cold hands/feet Tension Shoulder/arm/wrist P Eyes sensitive to light
- Restlessness Dizzy/lose balance hip/leg/knee/ankle P Nervousness/anxiety
- Forgetfulness Depression Head feels too heavy Pins/needles in legs
- Chest P Hard to concentrate Blood in urine Other _____

Since this injury, are your symptoms? Improving Getting worse About the same

When are your symptoms worst? Morning Afternoon Evening Night

How did you feel before the accident? _____

Ongoing conditions/complaints experienced before the accident? _____

Are your work activities restricted because of your injuries? Yes No If, yes, explain: _____

Describe your work duties: _____

Have you injured this area of your body before? Yes No Explain: _____

If you have been in other auto or work accidents, list year and describe briefly:

1. _____
2. _____
3. _____

Have you seen any other doctors as a result of this accident? Yes No Who? _____

What was the treatment (if any)? _____

Are you pregnant? Yes No Date of last menstrual period? _____

Have you consulted an attorney? Yes No Name _____

Patient/Guardian's Signature _____

Activities of Daily Living/Symptoms/Medications

Patient Name: _____

Date: _____

Daily Activities: Effects of Current conditions On Performance

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Bending	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Concentrating	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Doing computer Work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Gardening	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Playing Sports	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Recreation Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Shoveling	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sleeping	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Watching TV	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Carrying	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Dancing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Dressing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Lifting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Pushing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Rolling Over	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Working	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Climbing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Doing Chores	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Performing Sexual Activity	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Reading	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Running	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sitting to Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform

Patient Name: _____

Date: _____

Please mark P for in the Past, C for Currently have and N for Never

- | | | | | |
|---|---|---|---|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Pregnant (Now) | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Frequent Colds/Flu | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Impotence/Sexual Dysfun. | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Jaw Pain, TMJ | <input type="checkbox"/> Convulsions/Epilepsy | <input type="checkbox"/> Fainting | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Heart Problem |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Tremors | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Colon Trouble | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Diarrhea/Constipation | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Pain w/Cough/Sneeze | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Menopausal Problems | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Foot or Knee Problems | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Menstrual Problem | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Sinus/Drainage Problem | <input type="checkbox"/> Depression | <input type="checkbox"/> PMS | <input type="checkbox"/> Lung Problems |
| <input type="checkbox"/> Back Curvature | <input type="checkbox"/> Swollen/Painful Joints | <input type="checkbox"/> Irritable | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Kidney Trouble |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Mood Changes | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Gall Bladder Trouble |
| <input type="checkbox"/> Numb/Tingling arms, hands, fingers | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Liver Trouble | |
| <input type="checkbox"/> Numb/Tingling legs, feet, toes | <input type="checkbox"/> Allergies | <input type="checkbox"/> Trouble Sleeping | <input type="checkbox"/> Hepatitis (A,B,C) | |

List Prescription & Non-Prescription drugs you take: _____

Get Moving Chiropractic

Dr. Katy R. Mooberry DC and Dr. Isaac A. Mooberry DC
3045 Whitman Dr. #102 Evergreen, CO 80439 Ph: 303-670-7777 Fax: 303-482-1946

Doctor's Lien

I do hereby authorize the above doctor to furnish my attorney with a full report of my examination, diagnosis, prognosis, etc., of myself in regards to the accident or illness for which I have or will receive treatment at the office of the above doctor.

I hereby authorize and direct my attorney to hold in trust, and to pay directly to the doctor such sums as may be due and owing for chiropractic and other professional services rendered to me by treatment of my injury or illness which are due to the doctor. Further, I authorize my attorney to withhold such sums from any settlement, judgment, or recovery as may be necessary to adequately protect the doctor. I hereby further give a lien on my case to the doctor against any and all proceeds of any settlement, judgment, or recovery as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to the doctor for all medical bills incurred for services rendered me and that this agreement is made solely for the doctor's additional protection and in consideration of the doctor waiting for payment. I further understand that such a payment is not contingent on any settlement or judgment by which I may eventually recover. **I am personally responsible for any bills, regardless of the outcome of any legal claim or case.**

I have read and fully understand this document and I am voluntarily signing this document. I am directing my attorney to protect the doctor's interest at the time of settlement and I am assigning and conveying certain legal rights over to the doctor. I also know that I may not revoke this agreement at any time. I further agree that a photocopy of this document shall be as effective as the original.

Date: _____ Patient Name: _____

Date of Birth: _____ Patient's Signature: _____

The patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect the said doctor above named.

This lien does not constitute a request or agreement between the parties for the attorney or law firm to act as a collection agency for the above-named doctor/doctor's office.

Date: _____ Attorney's Signature: _____


Please date, sign, and return one copy in the attached reply envelope. Please keep one for your records. Thank you.

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:


I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Get Moving Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ / ____ / ____  *Witness Initials*
Patient or Authorized person's Signature Date

REGARDING: Services Received

I hereby authorize payment to be made directly to Get Moving Chiropractic, for all benefits which may be payable under a health care 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 Get Moving Chiropractic for any and all services I receive at this office.

_____ / ____ / ____  *Witness Initials*
Patient or Authorized person's Signature Date

**Notice of Privacy Practices Acknowledgement
Get Moving Chiropractic**

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

Patient Name or Legal Guardian (print)

Date

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date _____ Attempt _____

Staff Name _____

OUR OFFICE POLICIES

Welcome to GET MOVING CHIROPRACTIC!

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. Once you have read "Our Office Policies", if you have any questions or any of these policies are unclear to you, and you would like further explanation before submitting your **Application for Care**, please let our front desk know and a member of our staff will be happy to discuss them with you further. 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. Since the majority of patient care occurs in an open bay area, patients have a unique opportunity to observe firsthand the positive results that are achieved and the benefits derived from being under chiropractic care. 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.

□ **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. Chiropractic care at **Get Moving Chiropractic** 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) diversified adjustments OR 2) a variety of techniques to accomplish this goal, including but not limited to therapeutic exercises. 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.

□ **FIRST THINGS FIRST**- Prior to receiving chiropractic 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 that 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.

□ **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 will 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.

Get Moving Chiropractic Dr. Katy R. Mooberry DC, CACCP

30772 Southview Dr. #140 Evergreen, CO 80439 Phone: 303-670-7777 Fax: 303-482-1946

New Patient Consent Form

*Please read the following carefully and initial each statement on the line provided.

____ Financial Policy and Agreement: Payment is required for all office services on the day of service and may be paid by cash, check or credit card. There is a \$30 fee for all returned checks. Payment on the day of service is eligible for a cash discount if you have a zero balance. If you have insurance that pays for chiropractic care, we will be glad to bill them for you. You must pay deductibles and co-payments, if applicable, at the time of service. If you need assistance or need to make special arrangements please talk with us. I understand that I am financially responsible for all charges whether or not paid by insurance and if I terminate or suspend my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I will be responsible for any costs of collections, attorney's fees or court costs required to collect my bill. If my bill is turned over to collection, I will pay for the charge added to my account. **Insurance is billed by code; payment varies by plan.**

____ Patient Release and Agreement: I authorize the release of any information including diagnosis and the records of any treatment rendered to me or my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to Get Moving Chiropractic all medical benefits otherwise payable for medical services. I authorize the use of this signature on all my insurance submissions and to obtain medical records.

_____ Consent and Agreement: Chiropractic examination and therapeutic procedures (including chiropractic manipulation, ultrasound, heat and cold application, electrotherapy and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. These complications may include, but are not limited to soreness, inflammation, soft tissue injury, dizziness, burns, temporary worsening of symptoms, broken bones and strokes. The more serious complications are extremely rare. Additional information on side effects and complications is available upon request. It is also our policy to inform you of the procedure being performed and the risks and alternative treatments available. If your physician does not explain to your satisfaction, please ask for more information.

I have read and understand the above statements regarding treatment side effects and I also understand that there is no guarantee for a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal and if the results are not acceptable, we will refer you to another provider who we feel can assist you further.

THERE IS A 24 HOUR CANCELLATION POLICY OR YOUR ACCOUNT WILL BE CHARGED \$25.00.

I have read all three of the above agreements and I accept these terms and conditions.

Patient signature or Guardian if patient is under 18 years of age

Date