



**Patient Information**

**Contact Information**

Name \_\_\_\_\_ Preferred Name \_\_\_\_\_

Email address \_\_\_\_\_ Pronouns \_\_\_\_\_

Primary Phone Number ( \_\_\_\_\_ ) \_\_\_\_\_  Mobile  Home  Work

Additional Phone Number ( \_\_\_\_\_ ) \_\_\_\_\_  Mobile  Home  Work

Address \_\_\_\_\_

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

Sex  Male  Female Gender \_\_\_\_\_ Birth Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_\_

If a minor, Parent/Guardian Name(s) \_\_\_\_\_

Parent/Guardian Phone \_\_\_\_\_ Email \_\_\_\_\_

Marital Status  Single  Married  Divorced  Widow Number of Children \_\_\_\_\_

Occupation \_\_\_\_\_ Employer/School \_\_\_\_\_

Work/Student Status  Full time  Part time

Preferred Appointment Reminder Notification Method(s)  Email  Text  Both

How did you hear about us? \_\_\_\_\_





List all prescription medications your child is currently taking:

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List all over-the-counter medications/supplements your child is currently taking:

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List all surgical procedures your child has had:

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Have your child had significant past trauma?  No  Yes, \_\_\_\_\_

**Pregnancy and Birth History**

Pregnancy history unknown, \_\_\_\_\_

Where was your child born? \_\_\_\_\_

How were they born?  Vaginally  C-section

Describe your child's birth story: \_\_\_\_\_

Is there anything else pertinent to your visit today? \_\_\_\_\_

Name of person completing this form \_\_\_\_\_

Relationship to patient \_\_\_\_\_



**Informed Consent Document**

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

**Nature of Chiropractic Care.** The primary treatment used by Doctors 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 to move your joints. That may cause an audible noise, and you may feel a sense of movement.

**Analysis, Examination, Treatment.** As part of the analysis, examination, and treatment, you are consenting to the following procedures, but not limited to:

Spinal manipulative therapy	Range of motion testing	Therapeutic ultrasound
Palpation	Orthopedic testing	Hot/cold therapy
Vital signs	Basic neurological testing	Electric muscle stimulation
	Radiographic studies	

**Risk Inherent with Chiropractic Care.** As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. The Doctor will make every reasonable effort during the examination to screen for contraindications of care. These complications include, but are not limited to: muscle strain, burns, fractures, disc injuries, dislocations, cervical myelopathy, and costovertebral stains and separations. Some patients will feel some stiffness and soreness following the first few days of treatment.

**Other Available Treatment Options.** Other treatment options for your condition may include self-administered over-the-counter analgesics, rest, medical care, prescription drugs, hospitalization, and surgery. If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physicians.

**Risk of Remaining Untreated.** Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult and less effective the longer it is postponed.

**I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with my care provider(s) 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.**

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

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

Signature of Parent of Guardian (if a minor): \_\_\_\_\_

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

Doctor Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**Authorization for Care of a Minor**

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent/Guardian Name(s) \_\_\_\_\_

Relationship \_\_\_\_\_

I, hereby, authorize Evergreen Chiropractic to render any chiropractic services necessary for the treatment of the patient listed above. These services include but are not limited to: physical examination, chiropractic adjustments, therapeutic procedures, traction, electric muscle stimulation, and manual muscle work, within the scope of chiropractic practice.

I, hereby, give consent for the patient listed above to be treated even if I or another parent is unable to attend the appointment. As a parent/guardian, I am financially responsible for any services rendered during the visit. Any question or concerns can be directed toward the treating doctor at any time.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

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*For doctor to complete:*

As a Doctor of Chiropractic, we will perform services to the best of your ability, upholding the integrity of our practice. We will treat the patient with respect and only perform services we deem necessary for the treatment of the condition.

Doctor Name \_\_\_\_\_

Doctor Signature \_\_\_\_\_ Date \_\_\_\_\_



**Payment Information & Agreement  
Chiropractic**

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

**Insurance Information**

Insurance Company \_\_\_\_\_

Policy Holder:  Self  Spouse  Parent

Policy Holder Name \_\_\_\_\_ Birth Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Policy Holder Address (if different from above) \_\_\_\_\_

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

I authorize the release of any medical information necessary to process insurance necessary to process insurance billings.

I authorize payment and assignment of insurance benefits to the doctor's office.

I am personally responsible for supplying accurate and current information.

Patient Initials

**Financial Responsibility Acknowledgment**

I understand that **co-pays are due at the time of service.**

If I have **not yet met my deductible** and no co-pay is required, I agree to pay a **\$45 down payment** toward my account at the time of service. This payment will be applied to any charges determined by my insurance provider once claims are processed. I acknowledge that the final amount I owe may be **more than \$45**, in which case I will be billed for the remaining balance.

**I understand I am financially responsible for all charges and deductibles not covered by my insurance and/or if I supply false or incorrect billing information.** I authorize a photocopy of this statement to serve as an original.

Patient Initials



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

**Credit Card on File Authorization**

Card Number \_\_\_\_\_

Expiration Date \_\_\_\_\_ Security Code \_\_\_\_\_ Zip Code \_\_\_\_\_

While keeping a credit card on file is **not required**, it is **highly encouraged** for your convenience. Please indicate your preferred method of handling charges:

- Please charge my card for any and all charges, including balances remaining after insurance payments are processed.**

I authorize automatic charges to my card on file for co-pays, co-insurance, deductibles, and any remaining balances as they are billed.

- Please charge my card only after I have reviewed and approved each charge.**

You will contact me for confirmation before charging my card on file. I understand I am still expected to pay upon receipt of my statement.

- Do not charge my card on file.**

I understand I am responsible for all balances and will pay by another method upon receiving a statement.

Signature \_\_\_\_\_ Date \_\_\_\_\_



**Receipt of Notice for Privacy Practices**

I hereby acknowledge receipt of the Notice of Privacy Practices for Evergreen Chiropractic (formally known as “Jackson Chiropractic Clinic”) regarding my health information. I have been informed and understand the manner in which my health information shall be maintained, utilized, and disclosed by the Clinic and my respective rights therein. I also understand that the Notice furnished to me is subject to change at any time. I am aware that I may obtain a current copy of this Notice at any time by contacting (651) 483-4321.

**My signature below herein constitutes acknowledgment that I have been furnished a copy of the Notice of Privacy Practices for Evergreen Chiropractic.**

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

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

Signature of Parent of Guardian (if a minor): \_\_\_\_\_