Patient Name: _____ **Date:** _____

Women Only:

To the best of my knowledge I **am / am NOT** pregnant
(Circle one above)

Missed Appointments:

There is a possible fee charged for all appointments that are not canceled prior to scheduled visit.
Any massage appointment that is not canceled 24 hours prior to scheduled appointment will be charged $35 - $70

Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____,
have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic or physical medicine care.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Children: _____

Others: _____

No one: ____

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy. I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

Print Name: _____

Signature: _____ Date: _____