Patient Update Form

Date:_____ Patient #_____

Name:_____

Address:_____

Phone#_____

Our goal is to help you maintain a good state of health for a longer and more productive life. Please answer the following questions so we may evaluate the present state of your condition.

My principle health concerns today are:_____

The current character of pain is: (check all that apply)

Location:_____

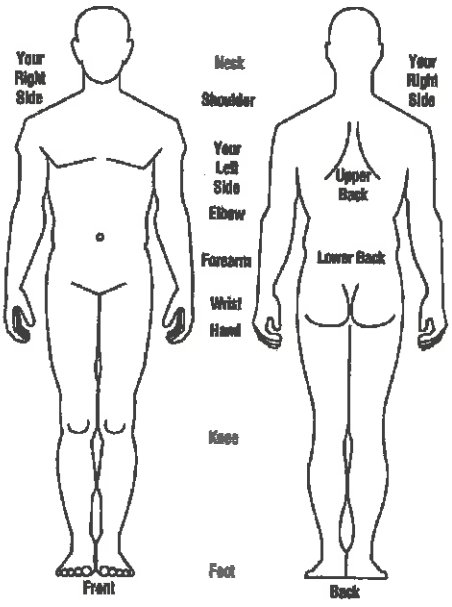
__ Tightness __ Burning __ Throbbing

__ Numbness __ Sharp __ Stabbing

__ Ache __ Tingling __ Bone Pain

Other_____

__ Often __ Constant __Comes and Goes



Date New Condition Began:_____

What makes the pain worse?_____

What makes the pain better?_____

Is you condition due to an accident?_____ Date of Accident:_____

Patient signature:_____ Date:_____

Office Policy

1. It is our office policy that all services rendered in this office are charged directly to you, the patient, and that you are personally responsible for all payments, regardless of weather or not this office accepts insurance assignment.

2. All payments are expected at the time of service.

3. All insurance assignment patients must pay their deductible in full and the co-insurance at the time of service or at the end of the week. Insurance assignment patient's balances may not exceed $150.00 at any time.

4. Balances over 30 days may be subjected to an additional 3% per month.

5. Charges may be charged for missed appointments and those not cancelled without a 2 hour notice.

I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered to me will be immediately due and payable.

Consent to Treatment

I hereby authorize the physician to trat my condition as he or she deems appropriate through the use of Chiropractic Health Car, and I give authority for these procedures to be performed. I consent to the chiropractic treatment(s) offered or recommended to be by the clinician, including joint adjustment or manipulation or mobilization to the joints of my spine, pelvis, and extremities. I intend this consent to apply to all my present and future appointments at this clinic.

Patient
Name:_____Date:_____

Consent to treat a minor:_____
Guardian:_____