PURE LIFE
CHIROPRACTIC

NEW PATIENT APPLICATION FORM

WELCOME and THANK YOU for applying as a patient in our clinic. We are a very unique team specializing in researched-based spinal and postural rehabilitation. These methods have enabled our patients to achieve their optimal health; even when many other systems have failed. Because of this specialized approach, we may not accept you as a patient until we are absolutely certain we know the cause of your condition, that we can perform the necessary tests to establish an optimal rehab program for you, and are completely confident we can help you recover your health. Please know if we do accept you as a patient, we will then make specific recommendations based upon our understanding that your health will become your TOP PRIORITY. Thank you again for applying as a patient in our clinic.

PATIENT NAME _____

DATE COMPLETED _____

PATIENT INFORMATION

Name: _____ Age:____ Height:_____ Weight:_____ Gender: ☐ M ☐ F
Home Address:_____ Home Phone: (_____) _____
City, State, Zip: _____ Work Phone: (_____) _____
Email Address: _____ Cell Phone: (_____)_____
Birth Date:_____ Social Security #: _____ Marital Status: ☐ S ☐ M ☐ D ☐ W
Occupation:_____ Employer Name: _____
Spouse's Name:_____ Work Phone: _____Cell Phone:_____
Spouse's Employer:_____ Occupation:_____
Children's ages and name of their chiropractor: _____
How were you referred to this office? _____

PURPOSE FOR VISIT

Primary reason for this visit: _____
Please use the *General Symptoms Chart* on the next page to provide a detailed notion of your symptoms.
***If your symptoms are the result of an auto accident or work-related injury, please let the front desk person know.**
Are they getting worse? ☐ Y ☐ N It interferes with: ☐ Work ☐ Sleep ☐ Hobbies ☐ Daily Routine
Which activities aggravate your symptoms? _____
Is there anything that relieves your symptoms? ☐ Y ☐ N If yes, explain: _____
Have you experienced these symptoms before (if not accident/injury related?) ☐ Yes ☐ No
If yes, explain: _____
Have you been treated for this? ☐ Yes ☐ No When were you last treated? _____
Who did you see? _____
What treatment was performed? _____
How did you respond? _____

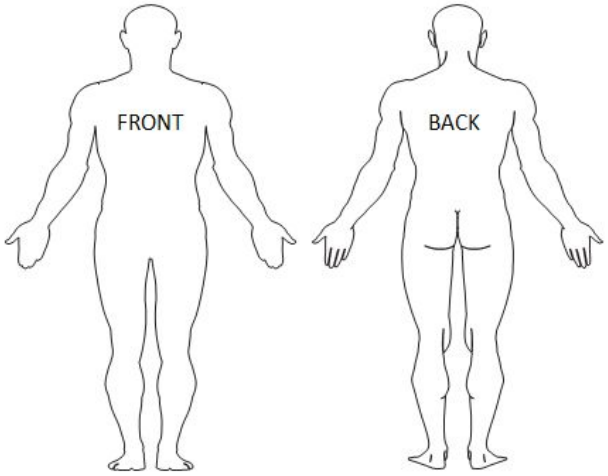
EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor before? ☐ Yes ☐ No Who? _____
Reason for visit:_____
Did your previous chiropractor take 'before and after' x-rays ☐ Yes ☐ No What was the diagnosis? _____
Did he or she recommend a specific course of treatment? ☐Yes ☐ No
Did they recommend a Home Health Care Program? ☐ Yes ☐ No
If yes, what?_____How long were you treated? _____ Last treatment:_____
How did you respond?_____
Are you aware of poor posture habits? ☐Yes ☐No Is there a history of spinal problems in your family? ☐ Yes ☐ No
If yes, explain: _____

GENERAL SYMPTOMS CHART

Please use the following notations on the figures below to indicate the type and location of your symptoms, as it related to the purpose of your visit today.

A = ACHE	K = STABBING	N = NUMBNESS
B = BURNING	S = SPASMS	T = TINGLING
P = PINS & NEEDLES	F = STIFFNESS	O = OTHER



How long have you had this pain?	Did it start with an injury? **A**uto **W**ork **O**ther	Quality: Sharp, Dull, Aching, Throbbing, Stabbing, Burning, Tension, Numbness, Tingling..	Location: Head, Neck, Upper Back, Mid Back, Lower Back, etc.	Pain radiates to my: Shoulders, Arms, Hands, Ribs, Thighs, Legs, Feet	Rate your pain on a scale of: 1 to 10	How often: **D**aily **3-4**X/week **1-2**X/week **M**onthy **I**nfrequent	When is the pain the worst? Morning, afternoon, night, movement..

HEALTH & LIFESTYLE

Do you exercise? ☐ Yes ☐ No How often? _____Day (s) per week;

☐ Walking ☐ Running ☐ Weight Training ☐ Cycling ☐ Yoga ☐ Swimming ☐ Other _____

Do you smoke? ☐ Yes ☐ No How much? / How often? _____

Do you take any supplements (i.e. vitamins, minerals, herbs? _____ If yes, please list:_____

_____

HEALTH CONDITIONS

Your spine is the foundation of health and core strength in your body. Shifts in the vertebrae or sections of the spine will spread, ultimately causing weakness and distortions to ALL of the areas of the spine. These distortions are reflected in abnormal posture. Research shows abnormal posture leads to chronic pain, disease and possibly a shortened life span. Please answer the following questions accurately so we may determine the full extent of your condition.

CERVICAL SPINE (NECK)

Misalignment of the individual vertebrae or distortion of the neck curve, or compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

Please indicate N = Now, P = Past next to all conditions you've experienced or both if applicable.

_____ Neck Pain	_____ Headaches	_____Sinusitis
_____ Pain in shoulders or traps	_____ Dizziness	_____Allergies/ Hay fever
_____ Numb/tingling in hands	_____ Visual disturbances	_____Recurrent colds/Flu
_____ Hearing disturbances	_____ Coldness in hands	_____ Low Energy/Fatigue
_____ Weakness in grip	_____ Thyroid conditions	_____ Jaw Pain/ Clicking

Please explain:_____

_____

THORACIC SPINE (UPPER BACK)

Misalignment of the individual vertebrae or distortion of the upper back curve, or compensation from postural distortions in other areas of the spine may result in many health conditions. Have you ever experienced any of these symptoms presently or in the past?

Please indicate N = Now, P = Past next to all conditions you've experienced or both if applicable.

_____ Heart palpitations	_____ Recurrent Lung Infections/Bronchitis
_____ Heart murmurs	_____Asthma/Wheezing
_____ Tachycardia	_____ Shortness of Breath
_____Heart attacks/Angina	_____Pain on Deep Inspiration/Expiration

Please explain: _____

_____

THORACIC SPINE (MID BACK)

Misalignment of the individual vertebrae or distortion of the mid back curve, or compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?
Please indicate N = Now, P = Past next to all conditions you've experienced or both if applicable.

_____ Mid Back Pain _____ Nausea _____Diabetes
_____Pain in Ribs/Chest _____Ulcers/Gastritis _____ Hypoglycemia/Hyperglycemia
_____ Indigestion/Heartburn _____ Reflux _____"Hangry"

Please explain: _____

_____

LUMBAR SPINE (LOWER BACK)

Misalignment of the individual vertebrae or distortion of the mid back curve, or compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?
Please indicate N = Now, P = Past next to all conditions you've experienced or both if applicable.

_____ Pain in hips/legs/feet _____Weakness in hips/legs/feet _____Low back pain
_____ Numbness/tingling legs/feet _____ Recurrent bladder infections _____ Coldness legs/feet
_____ Frequent/difficulty urinating _____Muscle cramps in legs/feet _____Sexual dysfunction
_____ Constipation/Diarrhea _____Prostate issues _____ Menstrual irregularities(female)

Please explain: _____

_____

OTHER

Past injuries or trauma:_____
Please list any health conditions not mentioned:_____
Please list any medications (include name, dose, for what condition, and how long you've been taking it):

_____

Please list any surgeries (include type of surgery and date it was performed:_____

_____

FAMILY HEALTH HISTORY

Have you or any of your family members ever been diagnosed with the following: ***(please indicate "Y" for you, and "O" for Other than you, or "B" for both):***

___ Diabetes ___Varicose Veins ___Neurological Problems ___Lung Disease
___ Rheumatic fever ___Circulatory Problems ___Stroke ___ Heart Murmur
___ High Blood Pressure ___ Heart Disease ___ Cancer ___ Osteoporosis
___ Kidney Disease ___ Paralysis ___ Migraines/Headaches ___ Arthritis
___ Liver Disease ___ Metal Implant ___ Infectious Disease ___ Gallbladder Issues
___ Broken Bones ___ Appendectomy ___Tonsillectomy ___ Hernia
___ Pneumonia/Bronchitis ___Polio ___Tuberculosis ___ Anemia
___ Whooping Cough ___ Chicken Pox/Shingles ___ Mumps ___ Measles
___ Thyroid Problems ___ Smallpox ___ Influenza ___ Pleurisy
___ Blood Sugar Problem ___ Epilepsy/Seizures ___ Eczema/Psoriasis ___ Low Back Pain

Oswestry Disability Questionnaire

This questionnaire has been designed to give us information as to how your **back or leg pain** is affecting your ability to manage in everyday life. Please answer by checking **one box in each section** for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply, but please just shade out the spot that indicates the statement which **most clearly describes your problem**.

Section 1: Pain Intensity
- I have not pain at the moment
- The pain is very mild at the moment
- The pain is moderate at the moment
- The pain is fairly severe at the moment
- The pain is very severe at the moment
- The pain is the worst imaginable at the moment

Section 2: Personal Care (eg. washing, dressing)
- I can look after myself normally without causing extra pain
- I can look after myself normally but it causes extra pain
- It is painful to look after and I am slow and careful
- I need some help but can manage most of my personal care
- I need help everyday in most aspects of self-care
- I do not get dressed , wash with with difficulty and stay in bed

Section 3: Lifting
- I can lift heavy weights without extra pain
- I can lift heavy weights but it gives me extra pain
- Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed (eg. on a table)
- Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- I can only lift very light weights
- I cannot lift or carry anything

Section 4: Walking*
- Pain does not prevent me walking any distance
- Pain prevents me from walking more than a mile
- Pain prevents me from walking more than ½ mile
- Pain prevents me from walking more than 100 yards
- I can only walk using a stick or crutches
- I am in bed most of the time

Section 5: Sitting
- I can sit in any chair as long as I like
- I can only sit in my favorite chair as long as I like
- Pain prevents more sitting more than an hour
- Pain prevents me from sitting more than 30 minutes
- Pain prevents me from sitting more than 10 minutes
- Pain prevents me from sitting at all

Section 6: Standing
- I can stand as long as I want without extra pain
- I can stand as long as I want but it gives me extra pain
- Pain prevents me from standing for more than 1 hour
- Pain prevents me from standing for more than 30 minutes
- Pain prevents me from standing for more than 10 minutes
- Pain prevents me from standing at all

Section 7: Sleeping
- My sleep is never disturbed by pain
- My sleep is occasionally disturbed by pain
- Because of pain I have less than 6 hours of sleep
- Because of pain I have less than 4 hours of sleep
- Because of pain I have less than 2 hours of sleep
- Pain prevents me from sleeping at all

Section 8: Sex Life (if applicable)
- My sex life is normal and causes no extra pain
- My sex life is normal but causes some extra pain
- My sex life is nearly normal but is very painful
- My sex life is severely restricted by pain
- My sex life is nearly absent because of pain
- Pain prevents any sex life at all

Section 9: Social Life
- My social life is normal and gives me no extra pain
- My social life is normal but increases the degree of pain
- pain has no significant effect on my social life apart from limiting my more energetic interests (e.g sport)
- Pain has restricted my social life and I do not go out as often
- Pain has restricted my social life to my home
- I have no social life because of pain

Section 10: Traveling
- I can travel anywhere without pain
- I can travel anywhere but it does give me extra pain
- Pain is bad but I can manage journeys over two hours
- Pain restricts me to take journeys of less than one hour
- Pain restricts me to short necessary journeys under 30 minutes
- Pain prevents me from traveling except to receive treatment

NAME: _____ **DATE:** _____ **SCORE:** _____

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

PLEASE READ: **This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by SHADING OUT the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but *PLEASE JUST SHADE OUT THE ONE. CHOOSE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.***

SECTION 1 - Pain Intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

SECTION 2 - Personal care (washing, Dressing, etc.)

- I can look after myself normally without causing extra pain.
- I can look after myself normally but it causes extra pain.
- It is painful to look after and I am slow and careful.
- I need some help but can manage most of my personal care.
- I need help everyday in most aspects of self-care.
- I do not get dressed , wash with with difficulty and stay in bed.

Section 3 - Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives me extra pain.
- Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed (eg. on a table).
- Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights.
- I cannot lift or carry anything.

SECTION 4- Reading

- I can read as much as I want to with no pain in my neck.
- I can read as much as I want to with slight pain in my neck.
- I can read as much as I want to with moderate pain in my neck.
- I cannot read as much as I want because of moderate pain in my neck.
- I cannot read as much as I want because of severe pain in my neck.
- I cannot read at all.

SECTION 5 - Headaches

- I have no headaches at all.
- I have slight headaches which come infrequently.
- I have moderate headaches which come infrequently.
- I have moderate headaches that come frequently.
- I have severe headaches which come frequently.
- I have headaches almost all the time.

SECTION 6 - Concentration

- I can concentrate fully when I want to with no difficulty.
- I can concentrate fully when I want to with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

SECTION 7 - Work

- I can do as much work as I want to.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I cannot do any work at all.

SECTION 8 - Driving

- I can drive my car without any neck pain.
- I can drive my car as long as I want with slight pain in my neck.
- I can drive my car as long as I want with moderate pain in my neck.
- I cannot drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive at all because of severe pain in my neck.
- I cannot drive my car at all.

SECTION 9 - Sleeping

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hour sleepless)
- My sleep is mildly disturbed (1-2 hours sleepless).
- My sleep is moderately disturbed (2-3 hours sleepless).
- My sleep is greatly disturbed (3-5 hours sleepless).
- My sleep is completely disturbed (5-7 hours).

SECTION 10 - Recreation

- I am able to engage in all of my recreational activities with no neck pain at all.
- I am able to engage in all of my recreational activities with some pain in my neck
- I am able to engage in most, but not all of my recreational activities because of pain in my neck.
- I am able to engage in a few of my recreational activities because of pain in my neck.
- I can hardly do any recreational activities because of pain in my neck.
- I cannot do any recreational activities at all.

COMMENTS:_____

_____

_____

NAME:_____ **DATE:**_____ **SCORE:**_____

DISABILITY RATING SCALE FOR LOW BACK PAIN

US English Version of the Roland-Morris disability questionnaire

When your back hurts, you may find it difficult to do some of the things you normally do. This list contains some sentences that people have used to describe themselves when they have back pain. When you read them, you may find that some stand out because they describe you *today*. As you read the list, think of yourself *today*. When you read a sentence that describes you *today*, circle the number next to it. If the sentence does not describe you, then leave the number uncircled and go on to the next one. **Remember, only mark the sentence if you are sure that it describes you *today*.**

1. I stay at home most of the time because of the pain in my back.
2. I change positions frequently to try and make my back comfortable.
3. I walk more slowly than usual because of the pain in my back.
4. Because of the pain in my back, I am not doing any of the jobs that I usually do around the house.
5. Because of the pain in my back, I use a handrail to get upstairs.
6. Because of the pain in my back, I lie down to rest more often.
7. Because of the pain in my back, I have to hold on to something to get out of a reclining chair.
8. Because of the pain in my back, I ask other people to do things for me.
9. I get dressed more slowly than usual because of the pain in my back.
10. I only stand up for short periods of time because of the pain in my back.
11. Because of the pain in my back, I try not to bend or kneel down.
12. I find it difficult to turn over in bed because of the pain in my back.
13. My back hurts most of the time.
14. I find it difficult to turn over in bed because of the pain in my back.
15. My appetite is not very good because of the pain in my back.
16. I have trouble putting on my socks (or stockings) because of the pain in my back.
17. I only walk short distances because of the pain in my back.
18. I sleep less because of the pain in my back
19. Because of the pain in my back, I get dressed with the help from someone else.
20. I sit down for most of the day because of the pain in my back.
21. I avoid heavy jobs around the house because of the pain in my back.
22. Because of the pain in my back, I am more irritable and bad tempered with people.
23. Because of the pain in my back, I go upstairs more slowly than usual.
24. I stay in bed most of the time because of the pain in my back.

Name: _____ Date:_____ Score:_____

Pure Life Chiropractic
315 West Broadway Suite 100 ● Eugene, Oregon 97401
Tel: (541) 343-5633 ● Fax: (541) 762-5633

Name:_____ **Date:**_____

Please check any symptoms that you have experiences since the collision/injury.
Add any comments as necessary.

- ❑ **Sleep disturbances** _____
- ❑ **Difficulty falling asleep** _____
- ❑ **Difficulty staying asleep** _____
- ❑ **Sleepiness** _____
- ❑ **Nightmares**_____
- ❑ **Fatigue** _____
- ❑ **Lethargic/Dozing** _____
- ❑ **Concentration loss** _____
- ❑ **Nervousness** _____
- ❑ **Difficulty with attention span** _____
- ❑ **Difficulty speaking or finding words** _____
- ❑ **Difficulty remembering numbers** _____
- ❑ **Difficulty planning or organizing** _____
- ❑ **Disorientation** _____
- ❑ **Confusion** _____
- ❑ **Reduced confidence** _____
- ❑ **Feelings of frustration** _____
- ❑ **Loss of memory** _____
- ❑ **Agitation, Anger, irritability or outbursts** _____
- ❑ **Flashbacks to the time of the injury** _____
- ❑ **Fear of driving again/ Fear while driving** _____
- ❑ **Apathy** _____
- ❑ **Personality changes** _____
- ❑ **Appetite changes/Loss of appetite** _____
- ❑ **Stomach upset/Digestive disturbances** _____
- ❑ **Nausea** _____
- ❑ **Dizziness/Balance loss/ Vertigo** _____
- ❑ **Hearing difficulty** _____
- ❑ **Buzzing or ringing in the ears** _____
- ❑ **Depression** _____
- ❑ **Vision changes/ Double vision/SPots or floaters in vision** _____
- ❑ **Shortness of breath** _____
- ❑ **Sexual dysfunction** _____
- ❑ **Pain, popping, clicking or grinding feeling in jaw** _____

PATIENT INFORMED CONSENT FORM AND ARBITRATION AGREEMENT

I hereby request and consent to the performance of Chiropractic adjustments and other Chiropractic procedures, including examination, various modes of physiotherapy (ultrasound, stretching, exercise, etc.), physiological therapeutics (mineral/vitamin supplementation, homeopathic formulations, etc.) and diagnostic x-rays, on me (or on the patient named herein, for whom I am legally responsible) by the licensed Doctors, therapists, and assistants of Pure Life Chiropractic.

I understand that I have an opportunity to discuss with the Doctor or staff the nature and purpose of Chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of Chiropractic there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations, aggravations of inflammatory conditions, sprains and strains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

I further understand that there is no guarantee or assurance as to the results of any procedures. In the event the undersigned has a dispute with the doctor or office the undersigned agrees that such dispute, if unresolved, will be referred to arbitration, according to Title 3, Sections 36 310 et seq. of the Remedial Code, Oregon Rules of Civil Procedure, before a neutral arbitrator selected by the parties or appointed by the court. Arbitration shall occur in Lane County, Oregon, and may be compelled by petition of either party to the court and any award resulting from such arbitration shall become binding on the parties, upon confirmation by the court. This arbitration clause shall not prevent the doctor or office from taking any action in any court to collect a debt owed by the undersigned. In the event of arbitration or litigation, the prevailing party shall recover reasonable attorney fees from the adverse party.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Signature of Patient_____ Date_____

Print Patient's Name_____ Date_____

Signature of Patient's Representative/Guardian _____ Relationship_____

Print Name of Patient's Representative/Guardian _____ Date_____

AUTHORIZATION OF CARE

I authorize and agree to allow the doctor and/or his designated staff to work with my spine or the spine of the charge I represent through the use of spinal adjustments and associated physiotherapy for the sole purpose of postural and structural restoration of normal biomechanical and neurological function. I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. The Doctor and/or his staff will not be held responsible for any health conditions or diagnoses which are pre-existing, diagnosed by another healthcare practitioner, or are not related to the spinal structural conditions diagnosed at this clinic. I also clearly understand that if I do not follow the doctors and/or staff's specific recommendations at this clinic that I will not receive the full benefit from these programs; and that if I terminate my care prematurely that all fees incurred will be due and payable at that time.

Patient's Signature_____ Date_____

Print Patient's Name_____

If patient is a legal charge of limited capacity requiring guardianship for treatment, please complete the following:

Date Guardianship Awarded _____ County, State of Guardianship_____

I hereby authorize the doctor of administrator care as deemed necessary to my charge as appointed to by the courts.

Guardian Signature _____ Date_____

Print Guardian's Name_____

NOTICE OF PATIENT PRIVACY POLICY - HEALTH INSURANCE AND PORTABILITY ACCOUNTABILITY ACT

Pure Life Chiropractic, LLC (PLC) is dedicated to preserving your "Protected Health Information" (PHI). We are required by law to protect your health information and to provide you with a notice describing how your medical information may be used and disclosed and how you can access this information. This notice of Privacy Practices describes your rights and the duties of PLC in regards to your protected health information.

- PLC may use or disclose your PHI for the purpose of diagnosing or providing treatment, obtaining payment for health care bills or to conduct health care operations.
- We may be required by law to use and disclose your medical information for other purposes without your consent or authorization.
- Your PHI means health information, including your demographic information, collected by other health care providers, a health care clearinghouse, an employer, or us. This protected health information relates to your past, present, or future physical or mental health or condition and identifies you, or there is a reasonable basis to believe the information may identify you.
- You are provided the right to inspect and receive a copy of your medical information that we maintain, amending or correcting that information, obtaining and accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, request that we restrict certain uses and disclosures of your health information, and file a complaint if you believe your rights have been violated. All requests and complaints must be made in writing.
- We have available a detailed NOTICE OF PATIENT PRIVACY POLICY (long form) which fully explains your rights and our obligation under the law. You have the right to receive a copy of our most current NOTICE in effect, please ask the front desk and we will provide you with a copy.
- As per the 2012 HIPAA mega rule, we will request authorization before disclosing for marketing purposes or the selling of your PHI. We will also give you the option to opt out of receiving fundraising communications. You also have the right to restrict the disclosure of your PHI in certain situations. If there is a breach in your unsecured PHI, you will receive notification of said breach. As the Provider uses or maintains EHR, the individual has the right to obtain a copy of PHI in an electronic format; an individual may request this record be sent to another office. Request must be made in writing by the patient.

We may revise our notice from time to time. The Effective Date: September 30, 2013 indicates the date of the most current NOTICE in effect. If you have any questions, concerns or complaints about the NOTICE or your medical information, please contact our Compliance Officer at (541)343-5633. Or contact: https://oig.hhs.gov.

The Practice may communicate confidential information about me to the following individual(s):_____

_____

_____ _____ _____

Print Name Signature Date

PREGNANCY RELEASE

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

Patient's Signature:_____ Date_____

INSURANCE

We may accept assignment of insurance benefits. By signing this policy, you agree to assign your insurance benefits to this clinic. If benefits are not assignable or where your benefit is processed directly to you regardless of assignment, you agree to submit any payments received along with the explanation of benefits to this clinic within 10 days of receipt unless you have paid for the services in full at the time of service. In no case will an assignment alleviate you of your obligation for payment of services received.

Your insurance plan is a contract between you and your insurance company. This clinic is not a party to that contract and therefore cannot modify the terms of that contract. Payment for treatment you receive from this clinic is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you provide us with the necessary billing information, assign your benefits to this clinic, and agree to permit us to release the necessary medical information required to secure payment. We will make every effort to ensure that your insurance carrier properly processes your services for payment. In some circumstances we may require your assistance. If your insurance company has not paid your account in full within 60 days and you refuse to assist us in dealing with your carrier, the balance will be automatically transferred to your account and full payment will be due immediately.

DECLARATION

I clearly understand that all insurance coverage, whether accident, work related, or general coverage, is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier they are doing so strictly as a convenience to me. The doctor's office will provide any necessary reports or required information to aid in insurance reimbursement of services. I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

I understand that there could be some services that my insurance company does not cover, and I am willing to pay for these services.

Patient's Signature_____ Date _____

Signature of Person Authorizing Care (if different from patient):

_____ Date _____

Relationship to Insured_____

If you have not given us your insurance card(s) to copy, please fill in the following section:

Primary Insurance Company_____ Policy#_____

Phone # ( )_____

Insured's Name (If different from the patient)_____ Insured's Social Security # _____

Secondary Insurance Company_____ Policy#_____

Phone # ( ) _____

Insured's Name (If different from the patient)_____ Insured's Social Security #

_____

PHOTO/VIDEO CONSENT AND RELEASE FORM

Without expectation of compensation or other remuneration, now or in the future, I hereby give my consent to Pure Life Chiropractic, its affiliates or agents, to use my image and likeness and/or any interview statements from me in its publications, advertising or other media activities (including the Internet). This consent includes, but is not limited to:

(a) Permission to interview, film, photograph, tape, or otherwise make a video reproductions of me and/or record my voice.
(b) Permission to use my first name; and last initial.
(c) Permission to use quotes from the interview(s) (or excerpts of such quotes), the film, photograph(s), tape(s) or reproduction(s) of me,, and/or recording of my voice, in part or in whole, in its publications, in newspapers, magazines and other print media, on television, radio and electronic media (Including the internet), in theatrical media and/or in mailings for educational and awareness.

This consent is given perpetuity, and does not require prior approval by me.

Name: _____

Signature: _____

Address: _____

_____

Date: _____

This below signed parent or legal guardian of the above-named minor child hereby consents to and gives permission to the above on behalf of such minor child.

Signature of Parent
Or Legal Guardian: _____ Print Name: _____

The following is required if this consent form **in full** to the parent/ legal guardian those signature appears above.

_____ _____

Date Witness Signature