



LARRY W. FULK, D.C. JAIME N. TRENT, D.C. JUSTIN L. FULK, D.C.

Patient Information

Full Name: _____ Today's Date: _____

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

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail address: _____ Social Security #: _____ - _____ - _____

Marital: M S W D Ethnicity: _____ Birth Date: __/__/__ Age: _____

Do you have children? Yes No What ages? _____

How were you referred to our office?

- Friend/Family Member – Who may we thank: _____
- Yellow Pages Our Sign Newspaper Column Fitness Center Website
- Health Screening Special Promotion: _____ Other: _____

Occupation: _____ Employer: _____

Employer's Address: _____

Spouse: _____ Spouse's Employer: _____

Name of Nearest Relative: _____ Phone: _____

Address: _____

Please check any and all insurance coverage that may be applicable in this case.

- Major Medical Worker's Compensation Medicare Auto Accident Other None

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company (if any): _____

As a courtesy, we will file insurance claims for you. It is important to note that your insurance coverage is a contract between you and your insurance company, not our office and your insurance company. This service is provided as a courtesy only and does not substitute for payment. Many insurance companies pay fixed allowances for certain procedures while many others pay a percentage of the charge. "Reasonable and Customary Fees: are determined by your insurance carrier and may vary greatly between carriers. **It's your responsibility to pay any deductible amount, co-insurance or any other balance not covered by your insurance company.**

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 16%.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature _____ Date _____

Guardian's Signature Authorizing Care _____ Date _____

FULK CHIROPRACTIC & ACUPUNCTURE, LLC - INFORMED CONSENT

The primary treatment used by doctors of chiropractic is the spinal manipulation, sometimes called spinal adjustment.

♦ **The nature of the chiropractic adjustment.**

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel or sense movement.

♦ **The material risks inherent in chiropractic adjustment.**

As with any healthcare procedure, there are certain complications, which may arise during chiropractic manipulation. Those complications include: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

♦ **The probability of those risks occurring.**

Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare."

♦ **The risks and dangers attendant to remaining untreated.**

Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult to treat and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have had all my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself 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.

DATE _____

Printed Name

Signature

Signature of Parent or Guardian (if a minor)

WITNESS:

Printed Name

Signature