in8 chiropractic

"Our Mission is to Improve Quality of Life Through Affordable Chiropractic Care".

VITAL INFORMATION

Name _____ Date _____

Address _____ City, State _____ Zip _____

Date of Birth _____ Age _____ Gender M F

Home Phone _____ Cell Phone _____

Email Address: _____ Marital Status: _____

*Patient contact information is not shared with other entities. Email addresses are used to notify patients of schedule changes or other information related to in8 chiropractic.

Reason for seeking services at in8 chiropractic

Who can we thank for referring you to us? _____

Is there anything about your spine and/or nervous system that we should know about? (ie. previous surgeries)

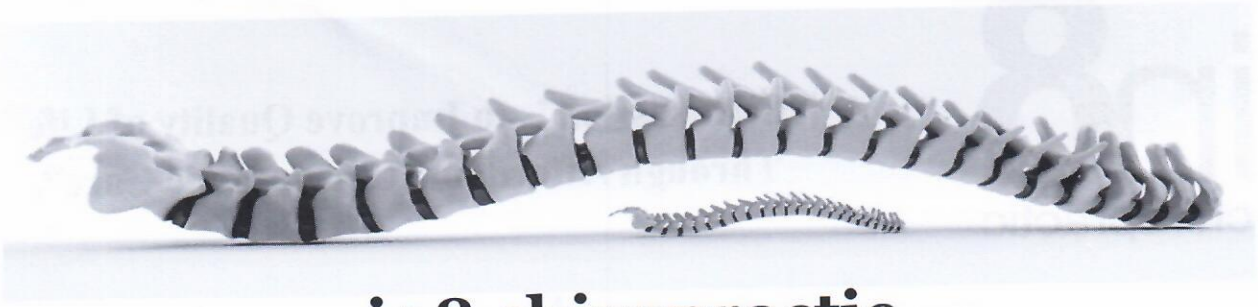
Any other health related concerns / challenges? Any previous diagnosis?

For Women Only

Are you pregnant? ___ No ___ Yes If so, in what week of pregnancy are you? _____

_____

Signature Date



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INFORMED CONSENT

I understand that if I am involved in an auto accident, or personal or work related injury, that I must inform in8 chiropractic prior to treatment, and if I elect to receive care, it is unrelated to the injury.

_____

I understand and acknowledge that in8 chiropractic will not bill, submit claims, nor prepare reports for any automobile, personal, or work related injury or any other third party payer. _____

I understand in8 chiropractic does not treat patients involved in litigation. Furthermore, I understand that if I need reimbursement by any type of insurance coverage or third party payer, I will be referred to another practitioner for my care. in8 chiropractic does not accept Medicare patients nor do they offer advice regarding treatment prescribed by others. _____

I understand in8 chiropractic does not diagnose or treat any disease or condition other than vertebral subluxation. Regardless of what the disease or symptom is called, in8 chiropractic does not offer to treat it. _____

I _____ have read and understand the above statements.
Print name

All questions regarding in8 chiropractic's objectives pertaining to my care have been answered and I accept care on this basis.

_____ _____
Signature Date

Consent to evaluate and adjust a minor child:

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 care.

_____ _____
Signature of legal guardian Date