Forever Young Chiropractic

CONFIDENTIAL PATIENT INFORMATION FORM – PLEASE PRINT

ADULTS

Date: _____

PATIENT INFORMATION

Name: _____
(LAST) (MI) (FIRST)

Address: _____
(STREET) (CITY) (STATE) (ZIP)

Home Phone: _____ Cell Phone: _____

Email Address: _____ Occupation: _____

Sex: Male Female Marital Status: Single Married Divorced

DOB: _____ Social Security #: _____

Emergency Contact: _____ Phone Number: _____

Relationship to Patient: _____

Who can we thank for the referral? _____

INSURANCE INFORMATION

Insurance Type: Health Personal Pay PI/Auto

Insurance Name: _____

Member #: _____ Group #: _____

Insurer's Name: _____ Insurer's DOB: _____ Insurer's Soc. Sec. #: _____

Insurer's Employer: _____ Person responsible for account: _____

Assignment of Benefits

I hereby give my consent to Forever Young Chiropractic to provide services to me and/or my family. I understand that I am financially responsible for all charges whether or not paid by insurance and that fees are payable at the time services are rendered. The above-named doctor may use my health care information and may disclose such information to the above-named insurance company (ies) and their agents for obtaining payment for services and determining insurance benefits payable for related services. **I hereby agree to such fees and understand that I am liable for any and all legal fees and/or reasonable interest if collection services become necessary.**

Parent/Guardian Signature: _____ Date: _____

Forever Young Chiropractic

CONFIDENTIAL DETAILED HISTORY FORM – PLEASE PRINT

ADULTS

HEALTH HISTORY

Patient Name:_____ Date:_____

What is the reason for your visit? _____

When did the symptoms start? _____

How long have you been experiencing these symptoms? _____

Has it gotten better or worse over time? Better: _____Worse: _____
About the same: _____Comes and goes:_____

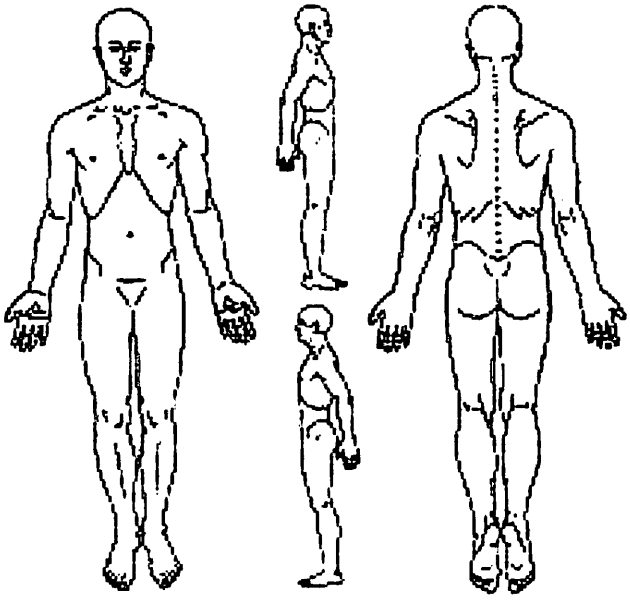
Does it affect your daily activities? Yes:____No:___
If "yes", please list what activities:_____
_____

How would you describe the pain? Dull:_____Achy:_____Sharp: ____ Shooting: ____ Cramping: ____
Tight: ____ Stiff: ____ Numb: ____ Tingling: ____ Burning: ____ Swelling: ____ Other: ____

How often do you experience the symptoms?
Intermittently (0-25% of the day): ____ Occasionally (26-50% of the day): ____
Frequently (51-75% of the day): ____ Constantly (76-100% of the day): ____

Have you ever received any other care for this condition? Yes:____No:___
If "yes", please list who else you have seen:_____
_____

Please mark on (X) on the picture where you are experiencing pain:



PAIN SCALE (please circle):

No pain Worst pain
0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Personal Information

Height:_____ Weight:_____ Age:_____

Any recent changes in your weight? Yes:___No:___
If "yes", please describe:_____

Have you ever had any X-Rays or other images done? Yes:___No:___
If "yes", please describe the reason:_____
_____
_____

Have you ever had any major falls or injuries? Yes:___No:___
If "yes", please describe what happened: _____
_____

Have you ever been hospitalized? Yes:___No:___
If "yes", please explain: _____
_____

Have you had any surgeries? Yes:___No:___
If "yes", please explain: _____
_____

Have you ever been in an auto accident? Yes:___No:___
If "yes", please list when: _____
_____

Are you currently taking any medications? Yes:___No:___
If "yes", please list below:
Name:_____Function/Purpose:_____
Name:_____Function/Purpose:_____
Name:_____Function/Purpose:_____
Name:_____Function/Purpose:_____
Name:_____Function/Purpose:_____

Are you currently taking any vitamins or supplements? Yes:___No:___
If "yes", please list below:
Name:_____Function/Purpose:_____
Name:_____Function/Purpose:_____
Name:_____Function/Purpose:_____
Name:_____Function/Purpose:_____
Name:_____Function/Purpose:_____

Are you allergic to anything? Yes:___No:___
If "yes", please describe:_____
_____

Have there been any changes in your bowel/ bladder function? Yes:___No:___
If "yes", please describe:_____

Do you smoke? Yes:___No:____
If "yes", please list # per day and for how long:_____

Do you drink? Yes:___No:____
If "yes", please list what and how many per week:_____
_____

Do you drink coffee? Yes:___No:____
If "yes", how many cups per day:_____

Do you drink tea? Yes:___No:____
If "yes", how many cups per day:_____

Do you diet? Yes:___No:____
If "yes", please describe diet:_____

Do you eat fast food? Yes:___No:____
If "yes", how many times per week:_____

Do you exercise or play sports? Yes:___No:____
If "yes", please list type of exercise or sports, as well as the frequency:_____
_____

How many hours of sleep do you average per night:_____

PLEASE INDICATE BY CHECKING IN THE APROPRIATE SPACE ANY SYMPTOMS YOU ARE CURRENTLY EXPERIENCING OR HAVE EXPERIENCED IN THE PAST

THIS IS A CONFIDENTIAL HEALTH REPORT

__Alcoholism
__Anemia
__Antihypertensive Meds.
__Appendicitis
__Arteriosclerosis
__Arthritis
__Cancer
__Cardiovascular Dz.
__Chorea
__Cold sores
__Diabetes
__Diphtheria
__Eczema
__Emphysema
__Epilepsy
__Fever blisters
__Goiter
__Gout
__Heart disease
__Hypertension
__Influenza
__Lumbago
__Malaria
__Measles
__Miscarriage
__MTHFR
__Multiple Sclerosis
__Mumps
__Oral Contraceptives
__Ovarian Cysts
__Pleurisy
__Pneumonia
__Polio
__Rheumatic fever
__Scarlet fever
__Stroke
__TIAs
__Tuberculosis
__Typhoid Fever
__Ulcers
__Venereal Dz.
__Whooping Cough
__Other:_____
_____

	GENERAL		UPPER BODY		LOWER BODY
	Allergies		Pain in Shoulders		Low Back Pain
	Constipation		Pain Across Shoulders		Sciatica (L—R)
	Convulsion		Tension in Shoulders		Herniated Disk
	Depression		Bursitis (L—R)		Low Back Feels "Out of Place"
	Diarrhea		Arthritis (L—R)		Muscle Spasm in Low Back
	Dizziness		Muscle Spasm in Shoulders		Popping in Low Back
	Fainting		Pain Raising Arms		Arthritis in Low Back
	Fever		Pain in Upper Arm		Numbness into Buttocks
	Loss of sleep		Pain in Elbow		Tingling into Buttocks
	Loss of weight		Pain Bending Elbow		Pain into Buttocks
	Nervousness		Tennis Elbow		Pain in Hips
	Neuralgia		Pain in Forearm (L--R)		Pain Down Leg (L—R)
	Sweats		Pain in Wrist (L—R)		Numbness down back of leg
	Tremors		Pain in Hands (L—R)		Numbness down side of leg
	Vomiting		Pain in Fingers (L—R)		Tingling down back of leg
			Numbness into Hand		Tingling down side of leg
	HEAD		Tingling into Hand		Knee Pain (L—R)
	Headache		Cold Hands/ Fingers		Inside
	Sinus (Allergy)		Swelling in Hand		Outside
	Entire Head		Swelling in Fingers		Above Knee Cap
	Back of Head		Loss of Grip Strength		Below Knee Cap
	Fore Head		Arthritis in Wrist		Leg Cramps (L—R)
	Temples		Arthritis in Hands		Pain in Foot
	Migraines		Arthritis in Fingers		Pain in Ankle
	Head feels heavy				Cramps in Foot
	Loss of Memory		**MIDBACK**		Numbness in Foot/ Ankle
	Light headedness		Midback Pain		Tingling in Foot/ Ankle
	Blurred Vision		Pain BTW Shoulders		Numbness in Toes
	Double Vision		Pain into Front		Tingling in Toes
	Loss of Vision		Muscle spasms		Feet Feel Cold
	Loss of Balance		Pain with Deep Breath		Swelling in Foot/ Ankle
	Loss of Taste		Pain in Kidney Area		
	Loss of Hearing				**WOMEN ONLY**
	Pain in Ears		**CHEST/ ABDOMEN**		Pregnant
	Ringing in Ears		Chest Pain		Is Baby Breech?
	Buzzing in Ears		Shortness of Breath		Genital Cancer
			Pain into Ribs		Menstrual Pain
	NECK		Irregular Heartbeat		Irregular Cycle
	Pain in Neck		Rapid Heartbeat		Cramping
	Neck Pain w/ Movement		Chronic Cough		Birth Control
	Forward		Spitting up Blood		Hysterectomy
	Backward		Wheezing		Abortions
	Looking to Left/Right		High Blood Pressure		Miscarriage
	Bending to Left/Right		Low Blood Pressure		Menopause
	Pinching in Neck		Distention of Abdomen		
	Muscle Spasm in Neck		Hernia		**MEN ONLY**
	Popping sound in Neck				Urinary Frequency
	Feels "Out of Place"				Difficulty Starting
	Arthritis in Neck				Prostate Pain/ Swelling

PLEASE PLACE AN "X" IN THE BOX NEXT TO ANY SYMPTOMS YOU ARE/ HAVE EXPERIENCED

Please Fill Out If Applies

HEADACHE DISABILITY INDEX

NAME: _____ DATE: _____ AGE: ____ SCORES TOTAL: ____; E____; F____
(100) (52) (48)

INSTRUCTIONS: Please CIRCLE the correct response:

1. I have headache: [1] 1 per month [2] more than but less than 4 per month [3] more than one per week.
2. My headache is: [1] mild [2] moderate [3] severe

INSTRUCTIONS: ***PLEASE READ CAREFULLY:*** The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off "YES", "SOMETIMES", or "NO" to each item. Answer each item as it pertains to your headache only.

	YES	SOMETIMES	NO
E1. Because of my headaches I feel handicapped.	☐	☐	☐
F2. Because of my headaches I feel restricted in performing my routine daily activities.	☐	☐	☐
E3. No one understands the effect my headaches have on my life.	☐	☐	☐
F4. I restrict my recreational activities (e.g. sports, hobbies) because of my headaches.	☐	☐	☐
E5. My headaches make me angry.	☐	☐	☐
E6. Sometimes I feel that I am going to lose control because of my headaches	☐	☐	☐
F7. Because of my headaches I am less likely to socialize.	☐	☐	☐
E8. My spouse/significant other, or family and friends have no idea what I am going through because of my headaches.	☐	☐	☐
E9. My headaches are so bad that I feel I am going to go insane.	☐	☐	☐
E10. My outlook on the world is affected by my headaches.	☐	☐	☐
E11. I am afraid to go outside when I feel a headache is starting.	☐	☐	☐
E12. I feel desperate because of my headaches.	☐	☐	☐
F13. I am concerned that I am paying penalties at work or at home because of my headaches.	☐	☐	☐
E14. My headaches place stress on my relationships with family or friends.	☐	☐	☐
F15. I avoid being around people when I have a headache.	☐	☐	☐
F16. I believe my headaches are making it difficult for me to achieve my goals in life.	☐	☐	☐
F17. I am unable to think clearly because of my headaches.	☐	☐	☐
F18. I get tense (e.g. muscle tension) because of my headaches.	☐	☐	☐
F19. I do not enjoy social gatherings because of my headaches.	☐	☐	☐
E20. I feel irritable because of my headaches.	☐	☐	☐
F21. I avoid traveling because of my headaches.	☐	☐	☐
E22. My headaches make me feel confused.	☐	☐	☐
E23. My headaches make me feel frustrated.	☐	☐	☐
F24. I find it difficult to read because of my headaches.	☐	☐	☐
F25. I find it difficult to focus my attention away from my headaches and on other things.	☐	☐	☐

Reference: Jacobson Gary P., Ramadan NM, et al., The Henry Ford Hospital Headache Disability Inventory (HDI). Neurology 1994; 44:837-842

FORM 502

Neck Index

Form N1-100

Please Fill Out If Applies

rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

~~Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100~~

Neck Index Score _____

Back Index

Form BI100

Please Fill Out If Applies

rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score _____

Forever Young Chiropractic

OFFICE POLICY

So that you will be aware of our office policy, please read the following information carefully. By executing this agreement, you are agreeing to pay for all services that are rendered. If at any time you have questions, please feel free to discuss the matter with any member of the staff.

MONTHLY STATEMENT

If you have a balance on your account, we will send you a monthly statement. Please make sure to pay any balances before they are over 30 days, after which they will be considered past due and a $3.00 service charge will be added.

PAYMENT OPTIONS IF YOU HAVE NO INSURANCE

1. Payment is due at time of service unless other arrangements are made.
2. Payment options are available such as cash, check or credit card.
3. For all products, payment is due at time of purchase.

PAYMENT OPTIONS IF YOU HAVE INSURANCE

1. Payment is due at time of service for your deductible and/or co-pay unless other arrangements are made.
2. Payment options are available such as cash, check or credit card.
3. For all products, payment is due at time of purchase.

INSURANCE

Insurance is a contract between you and your insurance company. We are not a party to this contract. We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company will pay, it is the insurance company that makes the final determination of your coverage. You agree to pay any portion of the charges not covered by insurance, including deductible, co-payments and any service rejected by your insurance company. If your insurance company continuously denies payment on a claim, it will become your responsibility to contact them.

INITIALS _____

RETURNED CHECKS

There is currently a $20.00 fee for any checks returned by the bank for insufficient funds.

CHIROPRACTIC APPOINTMENTS

- Most of our patients are seen by appointment only, except in emergency situations.
- While we try to accommodate walk-ins, we prefer our patients to schedule appointments to minimize waiting. Scheduled appointments are taken ahead of walk-ins.
- If you are unable to keep a scheduled appointment, we ask that you please give 24 hours' notice.
- Should an emergency arise, please call to let us know that you will not be keeping your appointment.
- For those who consistently miss appointments without notice, there will be a $20.00 missed appointment fee.

Patient/ Guardian Signature:_____

Today's Date:_____

FOREVER YOUNG CHIROPRACTIC

DOCTOR/PATIENT RELATIONSHIP IN CHIROPRACTIC

* INFORMED CONSENT FORM *

Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical, and spinal conditions. It is important to understand what to expect from chiropractic health care services.

A Doctor of Chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Complexes (VSC). When VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers.

A patient, in coming to the chiropractor, gives the doctor permission and authority to care for the patient in accordance with chiropractic tests, diagnoses, and analyses. The chiropractic adjustment or other clinical procedures are usually beneficial, and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment or health care if he/she is aware that such care may be contra-indicated. It is the responsibility of the patient to make it known, or to learn through health care procedures, whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the chiropractor. The chiropractor provides a specialized, non-duplicating health service. The chiropractor is licensed in a special practice and is available to work with other types of providers in your health care regime.

At Forever Young Chiropractic, we use a combination of different treatment procedures. We will use our hands, our adjusting table, and/or our activator device to deliver safe and gently adjustments. This may cause an audible "pop" or "click," much as you experience when you crack your knuckles. You may or may not experience or feel a sense of movement in the joint being adjusted.

Conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions that do not respond to chiropractic care may come under the control, or be helped through, medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both make great strides in alleviating pain and controlling disease.

With any health care procedure there are certain complications that may arise, and we strive to inform you of such risks. High force, extreme rotation adjustments of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Massage and trigger point therapies have an associated risk of bruising and/or release of emboli. Heat therapies may cause first and second-degree burns and/or hemorrhage. Risks associated with over-the-counter medications and prescription drugs are undesirable side effects such as liver damage and patient dependence. The risks inherent in surgery include adverse reaction to anesthesia, iatrogenic mishap, and an extended convalescent period. The risks associated with remaining untreated are the formation of adhesions and reduction of mobility depending on the severity.

I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with my doctor and have had 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 (or said minor's interest) to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to Forever Young Chiropractic to perform the treatment and acknowledge that no guarantee as to the results that may be obtained from this treatment has been given to me.

Patient Name (please print):_____

Parent/Guardian (please print):_____

Patient/ Guardian Signature:_____

Date: _____

FOREVER YOUNG CHIROPRACTIC

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Forever Young Chiropractic (FYC) has the right to change its Notice of Privacy practices from time to time and that I may contact FYC at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name (please print):_____

Parent/Guardian (please print):_____

Patient/ Guardian Signature:_____

Date: _____

I give consent for my provider to discuss my medical care with the persons listed below:

Name:_____ Relationship:_____

Signature:_____

(Authorized Representative must show ID)

Name:_____ Relationship:_____

Signature:_____

(Authorized Representative must show ID)

Name:_____ Relationship:_____

Signature:_____

(Authorized Representative must show ID)