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# Consent to Treat Form

I hereby request and consent for performance of physical treatment, including various modes of physical therapy, massage therapy, exercise therapy, acupuncture and chiropractic manipulation on me by the provider who now or in the future treats me while employed by, working with, or associated with Axis Health.

I have had an opportunity to discuss with the provider and/or with other office personnel the nature and purpose of chiropractic adjustments and other procedures.  I understand that results are not guaranteed.

I understand and am informed that, as with the practice of medicine, there are some risks to treatments, including but not limited to: fractures, disc injuries, strokes, dislocations and strains.  I do not expect the provider to be able to anticipate and explain all risks and complications.  I consent to rely that the provider's judgment is in my best interest and will be exercised during treatment based upon the known facts.

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

_____

Patient's printed name

_____ _____

Patient's signature Date signed

If patient being treated is a minor or is physicallly or mentally incapacitated, legal guardian / representative is to complete the following:

_____ _____

Signature of patient's representative Date signed

**Today's Date:** _____ **Doctor/Provider being seen today:** _____

**Patient Information:**

Patient Name as it appears on government issued i.d.:

[First] _____ [Middle] _____ [Last] _____

Residential Address: _____

City: _____ State: _____ Zip code: _____

Billing Address [if different from residential]: _____

City: _____ State: _____ Zip code: _____

Cell phone #: _____ Home phone #: _____

Email: _____

Birthdate: _____ Gender: _____

Marital status: _____ SSN #: _____

**Additional Information:**

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone Number: _____

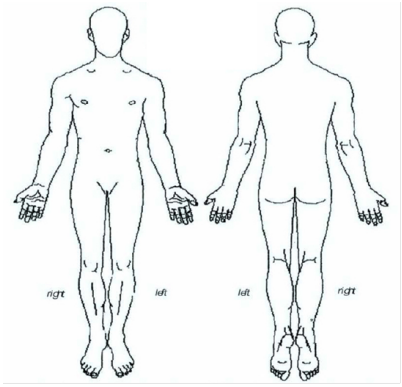
Relationship to Contact: _____

Primary Care Provider: _____ Date of last PCP visit: _____

Primary Care Provider Office: _____

**Patient Name:** _____ **D.O.B.** _____ **Age:** _____

**Present Complaints:** Please shade in the areas on the body diagram for which you are seeking treatment:




**Reason for today's visit:**

Symptoms (please describe in detail):

_____

How did these problems occur?: _____

How long have these symptoms been present?:_____

Are the symptoms getting worse?: ____ Not changing?: ____ Improving?: _____

What makes these symptoms worse?: _____

What makes these symptoms better?: _____

Are your symptoms better / worse at a certain time of the day? [circle one] Y N If "yes", when? _____

Have you ever had similar symptoms with the involved areas? Y N If "yes", when? _____

Please rate your symptoms from 1 – 10 [1 is no pain, 10 is the worst pain you've ever felt]: _____

Have you been treated by another chiropractor for this or any other problem? Y N If "yes" by whom and for what condition? _____

**Medical history / information:**

Have you had back or neck x-rays taken? Y N If "yes", when and where?

_____

Please list any medications you are currently taking: _____

Please list any surgeries that you have had: _____

Are you right or left handed? _____ What is your current weight? _____ Height? _____

Do you exercise? Y N If "yes", what do you do and how often? _____

Do you have a family history of health problems / diseases [siblings, parents, grandparents, etc.]? Y N

If "yes", please describe: _____

**Please place a check next to any conditions which you currently have or have had in the past.**

| | | | |
|---|---|---|---|
| Headaches ___ | General fatigue ___ | Lower back pain ___ | Jaw pain ___ |
| Low blood pressure ___ | Heart problems ___ | High blood pressure ___ | Upper back pain ___ |
| Loss of appetite ___ | Neck pain / stiffness ___ | Mid back pain ___ | Stroke ___ |
| Frequent urination ___ | Dermatitis / rash ___ | Diabetes ___ | Blood in stool ___ |
| Liver / gallbladder problems ___ | Gout ___ | Blood in urine ___ | Kidney stones ___ |
| Multiple sclerosis ___ | Painful urination ___ | Rheumatic fever ___ | Kidney disorders ___ |

Cancer ___ [If so, what kind]: _____

**Pain in [circle R for right, L for left]:**

| | | | | |
|---|---|---|---|---|
| Shoulders: R L | Arms: R L | Hands: R L | Joint stiffness / swelling ___ | Elbows: R L |
| Tailbone: ___ | Buttocks: ___ | Hips: R L | Thighs: R L | Knees: R L |
| Lower legs: R L | Feet: R L | Ankles: R L | Chest: ___ | Abdomen: ___ |

**Numbness or tingling in:**

| | | | |
|---|---|---|---|
| Face ___ | Upper back ___ | Shoulders: R L | Upper arms: R L |
| Forearms: R L | Hands: R L | Buttocks: ___ | Hips: R L |
| Thighs: R L | Lower legs: R L | Feet: R L | Ankles: R L |

**Other symptoms:**

| | | |
|---|---|---|
| Diagnosed with arthritis ___ | Scoliosis ___ | Sciatica ___ |
| Dizziness ___ | Fainting ___ | Ringing in ears: R L |

Do you use any of the following products? Drugs / Alcohol ___ Tobacco ___ Caffeine ___

Are you pregnant? Y N If "yes", how far along are you? _____

## Authorization to access medical records

This authorization must be written, dated and signed by the patient or by a person authorized by law to do so.

I authorize **Axis Health** to release and/or receive a copy of the medical information for

Patient's Name: _____ D.O.B. _____

Patient's Address: _____

City: _____ State: _____ Zip code: _____

By initialing the spaces below, I specifically authorize the release for the following medical records, if such records exist:

_____ All hospital records
_____ Most recent five year history
_____ Diagnostic imaging report
_____ Clinician office chart notes
_____ Physical therapy records
_____ Billing statements
_____ Transcribed hospital records
_____ Medical records needed for continuity of care
_____ Radiology films
_____ Consultations
_____ Emergency and urgency care conditions
_____ Progress Notes
_____ Please send medical records in entirity to the above clinic address

Other: _____

**Please read the following and sign below to ensure understanding and agreement:**

**Uses and Disclosures:** We use health information about you for your treatment, billing and healthcare operations. Continuity of care is part of treatment and your records may be shared with other providers to whom you are referred to through our clinic. Information may be shared through email, mail, fax or other methods requested. We may disclose identifiable information about you such as your name, date of birth, etc., without your authorization in several situations, but beyond those situations, we will ask you for your written consent before disclosing your information.

_____ _____

Patient Signature Date

_____

Printed Name

# Medical Insurance Disclaimer

We suggest to all patients that they contact their insurance to confirm that the services received in our office are covered. If you're unable to do so our office will check your health insurance benefits and coverage before or at the beginning of your first appointment.

If you do not have chiropractic insurance coverage we offer a discounted fee if you pay at the time of service. Our regular fees are well within the normal range for this area, so neither you nor your insurance company will be billed unfairly. It is not uncommon for insurance companies to delay payment for months, or to cut some or all charges as they see fit. In the event that payment is unreasonably delayed or reduced, you will be billed for the balance of your charges.

**Insurance disclaimer:** "A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service."

**Insurance liability for payment:** Your health insurance company will only pay for services that it determines to be "reasonable and necessary". Every effort will be made by this office to have all services and procedures preauthorized by your health insurance company. If your health insurance company determines that a particular service is not reasonable and necessary, or that a particular service is not covered under the plan, your insurer will deny payment for that service.

Under this arrangement, you are responsible for paying your co-pay, any non-covered portions, and any deductible you have yet to cover. In addition, if your insurance company does not pay for our services, you agree to pay for the services provided in our clinic. It is your responsibility as the patient to let our office know if your insurance carrier changes or you no longer have active coverage.

**I understand that my health insurance company may deny payment for the services identified above for the reasons stated. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, or co-insurance that applies.**

_____ _____

Patient Signature Date

_____

Printed Name