FREEDOM SQUARE CHIROPRACTIC

Joshua W. Bryan, D.C. **Greg W. Kofford, D.C.** **Larry G. Wilde, D.C.**

Department of Chiropractic & Physical Rehabilitation

COMPREHENSIVE HISTORY & INTAKE INFORMATION

Personal

Name _____ Date_____ Birth Date _____ Age_____ Height _____ Weight_____

Marital Status: ❑Married; name of spouse _____ ❑Single ❑Separated ❑Divorced ❑Widowed No. of Children_____

Employer _____ Work Phone_____ Occupation_____ SS# _____

Home Address _____ City _____ State _____ Zip_____

Home Phone _____ Cell Phone _____ Cell Carrier_____ Email_____

Which method is best to contact you for office reminders or promotional information: ❑Text ❑Email

Emergency Contact _____ Phone _____ Work or Cell Phone _____

Referred by _____ How did you hear about us? _____

Informed Consent

❑ **Chiropractic** — The scope of practice for a licensed Chiropractic Physician in the State of Utah includes but is not limited to the following list of procedures: Use of manual and mechanical joint mobilization of the spine and extremities. Use of thermal, ice, electrical, electromagnetic, and therapeutic ultrasound treatments based on Chiropractic diagnosis and concepts to restore proper nerve function, joint mobility, and soft tissue integrity. The recommendation of dietary guidelines and therapeutic exercise based on Chiropractic and Physical Rehabilitation diagnosis and theory. I recognize the potential risks and benefits of these procedures as described below:

Potential risks: Side effects may include, but are not limited to the following:
Aggravation of symptoms existing prior to the treatment. Mild inflammatory response of areas involved. Spasm of supporting muscles. Potential for rib fracture. Potential for stroke. Patients with bleeding disorders, pacemakers, seizure disorders, history of strokes, or women who are currently pregnant, please notify the practitioner.
Potential benefits: Drugless relief of presenting symptoms, increased function and mobility, improved general health, reduction of pain and associated symptoms.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Freedom Square Chiropractic regarding cure or improvement of my condition. I hereby release Freedom Square Chiropractic from any and all liability which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate care. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I have read or have had read to me the above statements and have had the opportunity to ask questions about its content and by signing below I agree to the terms and procedures.

Patient Name *(print clearly)* _____ **Patient Signature X**_____ **Date** _____
Patient Guardian *(complete only if patient is under 18 years of age)*
Name _____ Relation _____ Signature _____ Date _____

Authorization / Responsibility

Does your insurance company reimburse you for Chiropractic services? ❑Yes *❑No ❑Unsure

Name of Responsible Party *(Insurance Card Holder)* _____Date of Birth_____ SS# _____
Address *(if different from above)* _____ City/State/Zip_____
Phone _____ Employer _____ Work Phone _____ Marital Status_____
Primary Plan Name _____ Policy No._____
Address _____ City _____ State_____ Zip_____
Phone _____ Annual Deductible _____ Deductible Paid?_____
Secondary Insurance Plan _____ Policy No. _____
Address _____ City _____ State _____ Zip _____
Phone _____ Annual Deductible _____ Deductible Paid? _____

I authorize care and treatment by **Freedom Square Chiropractic**, their associates, and health care providers. I understand that payment is due prior to each visit and hereby agree to pay my account as services are provided. If payment is not received from either an insurance company or family within 30 days, I agree to pay 1.5% INTEREST CHARGES PER MONTH (18% ANNUAL INTEREST) on all unpaid balances over 30 days. Should any unpaid balances be referred to a collection agency, I agree to pay an additional collection fee (30-50% of AMOUNT DUE) plus reasonable attorney's fees. I also authorize releases of all information to insurance or other third party carriers and direct them to remit payments directly to the attending doctor. I acknowledge and understand that I am responsible for all of the charges for all of the services rendered to me or any member of my family. Although I may request Freedom Square Chiropractic to bill my insurance company on my family's behalf, I clearly understand that it is still my responsibility to make sure the bill is paid in a reasonable time. If for any reason, any portion of my bill is not paid by my insurance, I further agree to make arrangements for prompt payment of the bill. **We require 24 hours notice for cancelled appointments.** You may be charged a $25 fee for missed appointments, or dismissed from the practice. This office charges a $25 fee in addition to the check amount for each check returned by your bank.

Signature X_____ **Date** _____