HART
FAMILY CHIROPRACTIC

FAMILY HISTORY

Paternal Side: Heart Disease ___ Cancer/Type _____ Diabetes ___ Heavy Medication Use ___ Other ___
Maternal Side: Heart Disease ___ Cancer/Type _____ Diabetes ___ Heavy Medication Use ___ Other ___
Describe other:

_____

CHIROPRACTIC / PHYSICAL THERAPY

A Chiropractic Physician conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Complexes (VSC). When such 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. Due to the complexities of nature, no physician can promise you specific results. This depends upon the inherent recuperative powers of the body.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Further, I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. I authorize assignment of my insurance benefits directly to the provider.

HIPPA ACKNOWLEDGEMENT & CONSENT

Please read the two statements below, initial next to them, then print, sign and date below.

_____ I acknowledge that I have received a copy of our Notice of Privacy Practices.

_____ I consent to the release of protected health information that is required to carry out treatment, payment or healthcare operations on my behalf.

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I understand I am responsible for all bills incurred in this office.
- Person responsible for this account if other than the patient? _____
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance, my preferred payment method is: ☐Cash ☐Check ☐Credit Card ☐Car/Work Ins.
- Physical therapy appointments missed or cancelled within 24 hours will be charged $50.00

_____	_____	_____
(Please Print Patient Name)	(Signature)	(Date)
_____	_____	_____
(Parent/Guardian Name)	(Signature)	(Date)

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