Associated Chiropractic and Spinal Rehabilitation Center
427 West Harding Road, Springfield Ohio 45504
(937) 399-1159 (p) ~ (937) 399-1884(f)

Patient Name: ________________________________ **Date:** ____________________

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any questions please feel free to ask one of our staff members.

Informed Consent

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities, which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if a physician at Associated Chiropractic and Spinal Rehabilitation Center accepts me as a patient, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Women Only

To the best of my knowledge I **am / am NOT** pregnant and (**give my permission / don't give permission**) to x-ray me for diagnostic interpretation.
(Circle one above) *(Circle one above)*

Missed Appointments

There is a possible fee charged for all appointments that are not canceled prior to scheduled visit.
Any massage appointment that is not canceled 24 hours prior to the scheduled appointment will be charged $35 - $70.

Consent to Evaluate and Treat a Minor

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.

Communications

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse/Children/Other: ____ No one: ____

May we leave messages regarding your personal healthcare information on any answering device? Yes [ ] No [ ]

Referral Board

You may have been referred here by one of our patients. This type of new patient is one that we value most. We try hard to earn your confidence so that you may tell others how we have helped you. To acknowledge our appreciation for this type of referral, we like to list your name on our referral board in our waiting room for the month. Please check the box below stating you do or do not mind if we thank you by posting your name on our referral board.
Yes [ ] You may post my name No [ ] I prefer to not have my name displayed on the referral board

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: ____

Signature: ______________________________________ Date: _________________________