

Please take the time to fill out this questionnaire carefully. The information you provide will assist me in formulating a complete health profile for you. All your answers are absolutely confidential. If you have any questions, please ask.

## Health History

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Referred by: \_\_\_\_\_ Occupation: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

In Emergency Notify: \_\_\_\_\_ Phone: \_\_\_\_\_

**Main Complaint** (symptoms, diagnosis, duration, etc.)

---

**Significant Trauma** (physical or emotional)

---

**Birth History** (prolonged labor, forceps delivery, complications, etc.)

---

**Surgeries** (please include date of procedure)

---

**Allergies** (chemical, environmental, food, drugs, etc.)

---

**Medications** (names & dosages) Please attach an additional page if necessary.

---

**Vitamins/Supplements/Herbs**

---

**Exercise**

Days per week	Length of workout	Type of Activity
---------------	-------------------	------------------

**Diet**

Meals per day	Snacks	Caffeinated Drinks	Alcohol per week
---------------	--------	--------------------	------------------

## Personal History

Please check any conditions or symptoms you have now.

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Liver/Gall Bladder Disease | <input type="checkbox"/> Stroke                     | <input type="checkbox"/> Heart Disease              |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Hypo/Hyperglycemia         | <input type="checkbox"/> Kidney Disease             | <input type="checkbox"/> Elevated Blood Cholesterol |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Food Allergies/Intolerance | <input type="checkbox"/> Diverticulitis/IBS         |
| <input type="checkbox"/> Ulcer                   | <input type="checkbox"/> Seizures                   | <input type="checkbox"/> Hepatitis                  | <input type="checkbox"/> Raynaud's Disease          |
| <input type="checkbox"/> Chronic Fatigue         | <input type="checkbox"/> Anemia                     | <input type="checkbox"/> Thyroid Imbalance          | <input type="checkbox"/> Respiratory Allergies      |
| <input type="checkbox"/> Alcoholism              | <input type="checkbox"/> Lyme Disease               | <input type="checkbox"/> Chronic Pain Condition     | <input type="checkbox"/> Impotence                  |
| <input type="checkbox"/> Gastritis/Pancreatitis  | <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Infertility                | <input type="checkbox"/> Emphysema                  |

## Family Medical History

Please check any condition that applies to your immediate family. Put an F (father), M (mother), S (sister), B (brother), GM (grandmother), GF (grandfather) next to choice.

- |   |   |   |                                      |
|---|---|---|--------------------------------------|
| <input type="checkbox"/> Diabetes ____            | <input type="checkbox"/> Seizures ____  | <input type="checkbox"/> Heart Disease ____ | <input type="checkbox"/> Stroke ____ |
| <input type="checkbox"/> High Blood Pressure ____ | <input type="checkbox"/> Allergies ____ | <input type="checkbox"/> Cancer ____        | <input type="checkbox"/> Asthma ____ |
| <input type="checkbox"/> Other _____              |   |   |                                      |

Please check if you have had any of these items listed below in the last 3 months.

## General

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Poor Appetite           | <input type="checkbox"/> Poor Sleeping      | <input type="checkbox"/> Fatigue                            | <input type="checkbox"/> Fevers              |
| <input type="checkbox"/> Chills                  | <input type="checkbox"/> Night Sweats       | <input type="checkbox"/> Sweats Easily                      | <input type="checkbox"/> Tremors             |
| <input type="checkbox"/> Cravings                | <input type="checkbox"/> Localized Weakness | <input type="checkbox"/> Poor Balance                       | <input type="checkbox"/> Change in appetite  |
| <input type="checkbox"/> Bleed/Bruise easily     | <input type="checkbox"/> Weight loss/gain   | <input type="checkbox"/> Peculiar tastes/smells             | <input type="checkbox"/> Dental/gum problems |
| <input type="checkbox"/> Muscle weakness/fatigue | <input type="checkbox"/> Sudden energy drop | <input type="checkbox"/> Strong thirst (hot or cold drinks) |  |

## Skin and Hair

- |   |                                      |  |  |
|---|--------------------------------------|--|--|
| <input type="checkbox"/> Rashes             | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Hives/Allergic Dermatitis   | <input type="checkbox"/> Itching       |
| <input type="checkbox"/> Eczema/Psoriasis   | <input type="checkbox"/> Dandruff    | <input type="checkbox"/> Loss of hair                | <input type="checkbox"/> Recent moles  |
| <input type="checkbox"/> Skin discoloration | <input type="checkbox"/> Acne        | <input type="checkbox"/> Change in skin/hair texture | <input type="checkbox"/> Face flushing |
| <input type="checkbox"/> Dermatitis         | <input type="checkbox"/> Warts       | <input type="checkbox"/> Fungal Infection            |  |

## Head, Eyes, Ears, Nose and Throat

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Difficulty swallowing        | <input type="checkbox"/> Migraines              | <input type="checkbox"/> Glasses         |
| <input type="checkbox"/> Eye Strain           | <input type="checkbox"/> Eye pain                     | <input type="checkbox"/> Poor vision            | <input type="checkbox"/> Night Blindness |
| <input type="checkbox"/> Color Blindness      | <input type="checkbox"/> Cataracts                    | <input type="checkbox"/> Blurred vision         | <input type="checkbox"/> Earaches        |
| <input type="checkbox"/> Ringing in ears      | <input type="checkbox"/> Poor hearing                 | <input type="checkbox"/> Spots in front of eyes | <input type="checkbox"/> Sinus problems  |
| <input type="checkbox"/> Nose bleeds          | <input type="checkbox"/> Recurrent sore throats/colds | <input type="checkbox"/> Grinding teeth         | <input type="checkbox"/> Facial pain     |
| <input type="checkbox"/> Sores on lips/tongue | <input type="checkbox"/> Dental problems              | <input type="checkbox"/> Jaw clicks/locks       | <input type="checkbox"/> Headaches       |

## Cardiovascular

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Chest pain or pressure | <input type="checkbox"/> Irregular heart beat   | <input type="checkbox"/> Palpitations at rest | <input type="checkbox"/> Fainting            |
| <input type="checkbox"/> Cold hands/feet        | <input type="checkbox"/> Swelling of hands/feet | <input type="checkbox"/> Blood clots          | <input type="checkbox"/> Phlebitis           |
| <input type="checkbox"/> Shortness of breath    | <input type="checkbox"/> Varicose/spider veins  | <input type="checkbox"/> Pressure in chest    | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Low blood pressure     | <input type="checkbox"/> Spontaneous sweating   | <input type="checkbox"/> Dizziness            |  |

## Respiratory

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Cough/Wheezing                       | <input type="checkbox"/> Coughing blood            | <input type="checkbox"/> Asthma                                    | <input type="checkbox"/> Bronchitis              |
| <input type="checkbox"/> Pneumonia                            | <input type="checkbox"/> Pain with deep inhalation | <input type="checkbox"/> Tight sensation in chest                  | <input type="checkbox"/> Difficult inhale/exhale |
| <input type="checkbox"/> Difficulty breathing when lying down |  | <input type="checkbox"/> Production of phlegm... what color? _____ |  |

## Gastrointestinal

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Nausea              | <input type="checkbox"/> Vomiting             | <input type="checkbox"/> Diarrhea                  | <input type="checkbox"/> Constipation          |
| <input type="checkbox"/> Gas                 | <input type="checkbox"/> Belching             | <input type="checkbox"/> Black stools              | <input type="checkbox"/> Blood in stool        |
| <input type="checkbox"/> Indigestion         | <input type="checkbox"/> Bad breath           | <input type="checkbox"/> Rectal pain               | <input type="checkbox"/> Hemorrhoids           |
| <input type="checkbox"/> Bloating/Edema      | <input type="checkbox"/> Chronic laxative use | <input type="checkbox"/> Loose stools (>2 per day) | <input type="checkbox"/> Abdominal pain/cramps |
| <input type="checkbox"/> Changes in appetite | <input type="checkbox"/> Acid reflux/GERD     | <input type="checkbox"/> Hernia                    | <input type="checkbox"/> Poor appetite         |
| <input type="checkbox"/> Excessive appetite  | <input type="checkbox"/> Significant thirst   | <input type="checkbox"/> IBS/Crohn's Disease       |  |

## Genito-Urinary

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Pain on urination                                    | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Blood in urine          | <input type="checkbox"/> Urgent urination          |
| <input type="checkbox"/> Unable to hold urine                                 | <input type="checkbox"/> Kidney stones      | <input type="checkbox"/> Scanty flow             | <input type="checkbox"/> Copious flow              |
| <input type="checkbox"/> Impotence  | <input type="checkbox"/> Sores on genitals  | <input type="checkbox"/> Urinary tract infection | <input type="checkbox"/> Burning urination         |
| <input type="checkbox"/> Premature ejaculation                                | <input type="checkbox"/> Decreased libido   | <input type="checkbox"/> Prostatitis             | <input type="checkbox"/> Dribbling after urination |
| <input type="checkbox"/> Nocturnal emission                                   | <input type="checkbox"/> Pain in testicles  | <input type="checkbox"/> Herpes                  | <input type="checkbox"/> Infections                |
| <input type="checkbox"/> Night urination... What time? _____ How often? _____ |   |  |  |

## Gynecological/Reproductive

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Difficult/Painful intercourse | <input type="checkbox"/> Ovarian cysts              | <input type="checkbox"/> Age of first menses _____           |
| <input type="checkbox"/> Vaginal dryness               | <input type="checkbox"/> Endometriosis              | <input type="checkbox"/> Date of last menses _____           |
| <input type="checkbox"/> Vaginal sores                 | <input type="checkbox"/> Uterine Fibroids           | <input type="checkbox"/> Date of last PAP/Pelvic _____       |
| <input type="checkbox"/> Vaginal discharge             | <input type="checkbox"/> Fibrocystic breast tissue  | <input type="checkbox"/> Number of pregnancies _____         |
| <input type="checkbox"/> Infertility                   | <input type="checkbox"/> Polycystic Ovarian Disease | <input type="checkbox"/> Number of ectopic pregnancies _____ |
| <input type="checkbox"/> Irregular menstruation        | <input type="checkbox"/> PMS                        | <input type="checkbox"/> Number of live births _____         |
|  | <input type="checkbox"/> Painful menstruation       | <input type="checkbox"/> Number of miscarriages _____        |
|  |   | <input type="checkbox"/> Number of abortions _____           |

Do you practice birth control? \_\_\_\_\_  
What type? \_\_\_\_\_ How long? \_\_\_\_\_

## Musculoskeletal

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Neck pain                           | <input type="checkbox"/> Shoulder pain   | <input type="checkbox"/> Hand/wrist pain | <input type="checkbox"/> Carpal Tunnel   |
| <input type="checkbox"/> Knee pain                           | <input type="checkbox"/> Sprains/Strains | <input type="checkbox"/> Sciatica        | <input type="checkbox"/> Foot/ankle pain |
| <input type="checkbox"/> Hip pain                            | <input type="checkbox"/> Muscle pain     | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Tendonitis      |
| <input type="checkbox"/> Back pain Low___ Middle___ Upper___ |  | <input type="checkbox"/> Bursitis        | <input type="checkbox"/> Rotator Cuff    |

## Neuropsychological

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Seizures              | <input type="checkbox"/> Loss of balance      | <input type="checkbox"/> Vertigo/Dizziness            | <input type="checkbox"/> Areas of numbness           |
| <input type="checkbox"/> Lack of coordination  | <input type="checkbox"/> Poor memory          | <input type="checkbox"/> Concussion                   | <input type="checkbox"/> Depression                  |
| <input type="checkbox"/> Anxiety/Panic attacks | <input type="checkbox"/> Bad temper/irritable | <input type="checkbox"/> Easily susceptible to stress | <input type="checkbox"/> Seasonal Affective Disorder |
| <input type="checkbox"/> Nervousness           | <input type="checkbox"/> ADD/ADHD             | <input type="checkbox"/> Manic Depression             |  |

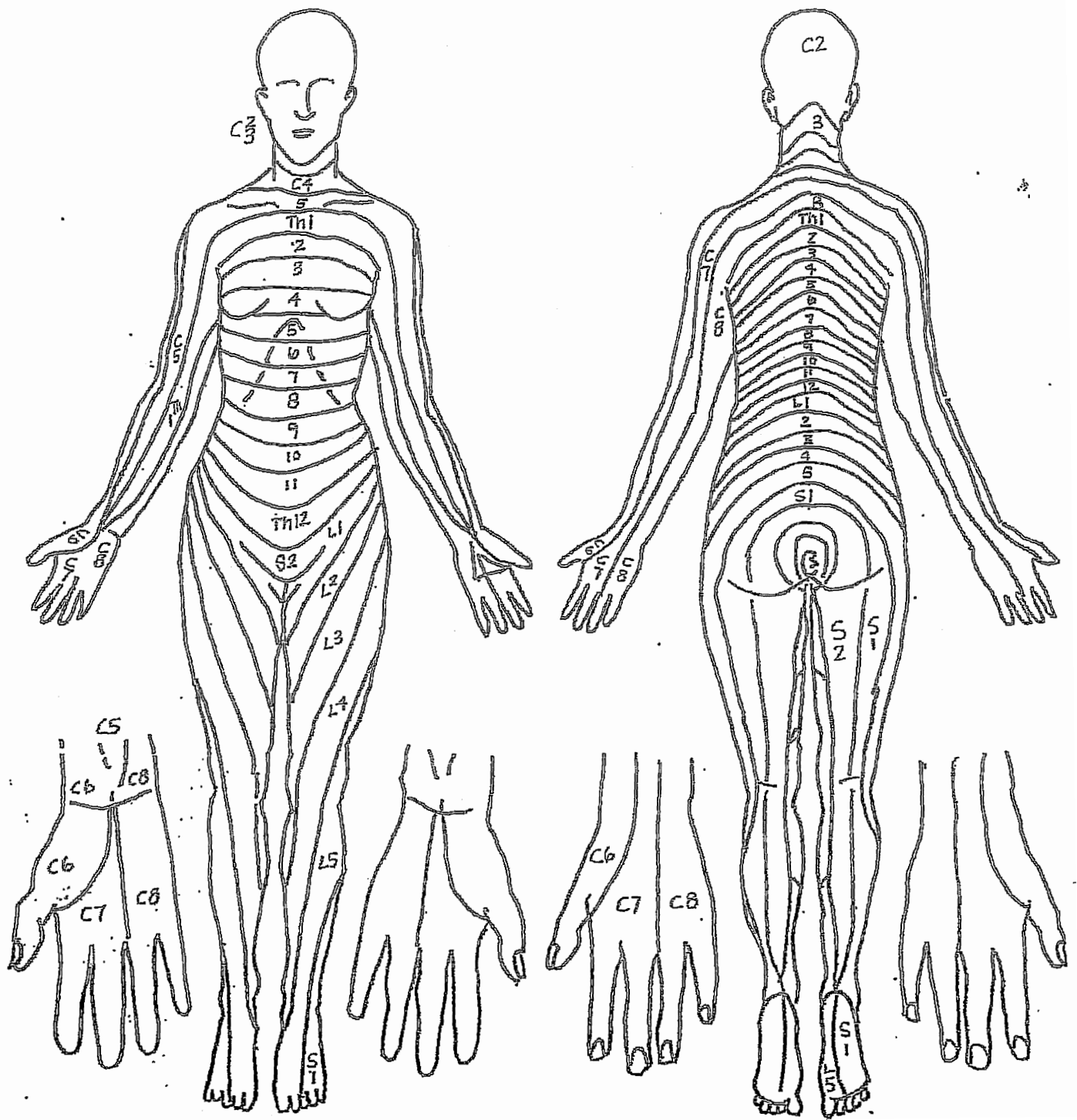
Have you ever been treated for emotional problems?  Yes  No  
Have you ever considered or attempted suicide?  Yes  No  
Have you ever been treated for substance abuse?  Yes  No

**Comments** Please inform me of any other problems you would like to discuss.

---

---

---



Please mark as specifically as possible the exact areas where you are experiencing discomfort.

PATIENT NAME:

### ARBITRATION AGREEMENT

**Article 1: Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

**Article 2: All Claims Must be Arbitrated:** It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

**Article 3: Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

**Article 4: General Provision:** All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

**Article 5: Revocation:** This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

**Article 6: Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. \_\_\_\_\_. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

**NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.**

PATIENT SIGNATURE **X** (Date)  
(Or Patient Representative) (Indicate relationship if signing for patient)

OFFICE SIGNATURE **X** (Date)

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

## ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE

X

(Or Patient Representative)

(Indicate relationship if signing for patient)

**ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE**

## Disclosure & Liability Waiver

I certify that I have informed Newton Chiropractic & Wellness Centre of all known physical, mental, and medical conditions and medications, including possible pregnancy, injuries, surgeries or medical procedures, and that I will notify Newton Chiropractic & Wellness Centre of any changes to my medical history.

I understand that I should consult a licensed physician for appropriate medical evaluation treatment of the conditions for which I am seeking acupuncture treatment. Treatment from this practitioner is not a substitute for appropriate medical treatment by a licensed physician. I have been advised that if there is a worsening of my ailment or condition, or if it does not improved within the time estimated by the acupuncturist at the beginning of the treatment, or if a new ailment or condition arises, I should again consult a licensed physician. If I am presently under the medical care of a physician, I have been advised to continue all medications and treatments as prescribed until such time as my physical deems it appropriate to reduce or discontinue the medication or treatments.

---

Signature of Patient

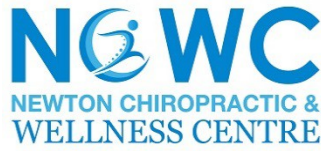
---

Date

---

Please PRINT your name





**PLEASE READ CAREFULLY BEFORE SIGNING – THANK YOU**

**PAYMENT POLICY**

- All persons are required to pay-in-full for services rendered at time of visit unless otherwise arranged. You may pay by cash, check or charge.
- If you would like us to accept insurance assignment (accept your insurance as payment), you must first apply through our finance department. Once you have been accepted for assignment, as a courtesy to you we will submit your bills directly to your insurance company(s).
- If you would like us to assist you in verifying whether your insurance will cover some or all of your care here, please show the receptionist your health insurance card. The finance department will then advise you of your options.
- You are responsible for your deductible, co-payments and any unpaid balance on your account if your insurance company, for any reason, does not honor their commitment to you.
- We will assist you to understand your policy limitations, but we suggest that you communicate directly with your current carrier with any questions or concerns you have regarding your specific policy, including chiropractic benefits.
- Wellness Care Packages and Care Plans have been created to provide you with an affordable payment option. Please keep track of how many visits you have used.

**CANCELLATION POLICY - (PLEASE READ CAREFULLY)**

Please notify us as soon as possible if you are unable to keep your appointment. Our answering machine is on 24-hours a day.

*Please help us to serve all members by providing us as much notice as possible.*

<b>Initials:</b>	<u>*Minimum 24-hour notice prior to a Chiropractic Appointment – Otherwise a \$25 fee will be charged to your account.</u>
_____	<u>*Minimum 48-hour notice prior to a 60-minute Massage Appointment – Otherwise a \$89 fee will be charged to your account. (\$125 fee will be charged for a 90-minute Massage appointment).</u>

*\* Please note - We will do our best to fill your missed appointment. You can also give your space to a friend or family member.*

*It is our commitment to serve as many people as we can, providing the highest quality care at an affordable rate.*

*In order to keep this commitment to the members of our practice, strict enforcement of the cancellation policy is necessary.*

I have read, understand, and agree to the above policies.

\_\_\_\_\_  
**Patient's signature**

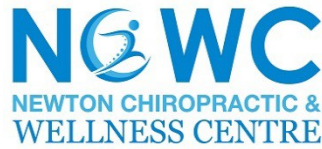
\_\_\_\_\_  
**Date**

I hereby assign any insurance payment directly to this office for professional services rendered and shall be personally responsible for any unpaid balance.

\_\_\_\_\_  
**Patient's signature**

\_\_\_\_\_  
**Date**





## PATIENT CONSENT FORM

Regarding the Use & Disclosure of Protected Health Information

("Consent Form")

For the purposes of this Consent Form, "Office" shall refer to: Newton Chiropractic Centre / Newton Chiropractic & Wellness Centre.

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled, "Our Privacy Practices." I understand that I may review this privacy notice at any time prior signing this form.

I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this Consent in, but only to the extent that the Office has not taken action in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

Patient Name (please print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: / / \_\_\_\_\_