Columbia Pike Chiropractic
Dr. Jaime A. Chica D.C

INFORMACION DE SALUD CONFIDENCIAL

Fecha de Hoy: ___________________ Chart Number:___________________________

Información Personal

Nombre:_________________________________ __________________ Apellido:____

Direccion:____ Apt: ________________

Ciudad:_______________________________ Estado________ Código Postal:_____________ Fecha de Nacimiento:__________________

Teléfono de Casa: ( )_________-___________ Numero de Seguro Social:____

Teléfono de Celular:( )_________-___________ Genero: ❑ Masculino ❑ Femenino

Teléfono Adicional: ( )_________-___________ Estado Civil: ❑Soltero(a) ❑Casado(a) ❑Divorciado(a) ❑Separado(a) ❑Viudo(a)

Correo Electrónico: ____

Nombre de su Cónyuge:__ ____ Edad de su(s) hijo(s):___________________________

Quien lo Refirió? ❑ Letrero del Edificio ❑ Paginas Amarillas ❑Medico Primario ❑Seguro ❑Abogado ❑ Internet ❑ Familia/Amigo ❑ _________________________

Empleador

Nombre del Empleador: ____ Ocupación:______________________________

Dirección: ____Ciudad:___________________ Estado:_____Código Postal:___________

Teléfono de Trabajo: ( )________-_____________ Numero de Fax: ( )________-_____________

Contacto en caso de Emergencia:

Nombre: ______________________________________ Relación:_______________ Numero de Teléfono: ( )______-___________

Modo de Pago? ❑Yo Pagare ❑Seguro Medico ❑Medicare ❑Seguro de Auto ❑Worker's Comp ❑Otro:________________

Nombre del Seguro: ____

Health ID Card No: ____

Group No:____

Quien es el portador encargado de la póliza?

❑Si mismo ❑Cónyuge ❑Padres

Nombre de Persona Asegurada: _________________________________ Fecha de Nacimiento: ____________________________

Medico Primario: ____ Tel del Medico Primario: ( )________-__________

Accidente de Auto (Información del Seguro de Auto)

Fecha del Accidente: _______________________ Donde Ocurrió el Accidente ? ____

Donde estabas en el Auto: ❑Conductor ❑Pasajero delantero ❑Pasajero trasero

Nombre de Su Seguro: ____ Numero de Reclamo__________________________________

Nombre de Seguro del Otro Carro: ____________________________________Numero de Reclamo__________________________________

Tiene Abogado? ❑Si ❑No Nombre de Abogado: ____

La información que presento es verdadera. Autorizo que los beneficios de mi seguro sean pagados directamente al Dr. Jaime Chica. Entiendo que soy económicamente responsable por cualquier balance. También autorizo a Columbia Pike Chiropractic o la Compañía de seguros a facilitar cualquier información requerida para procesar mis cuentas.

X ____ _______________________

Firma del Paciente/Guardian Fecha

HISTORIA CLINICA

Nombre: ____ Fecha: _____________

☐ Accidente Carro. ☐ Accidente Trabajo D.O.A: ________

QUEJA PRINCIPAL

Localización Dolor: ☐ Cabeza ☐ Cuello ☐ Mitad espalda ☐ Cintura ☐ Pecho ☐ Costillas ☐ Hombro Der. ☐ Hombro Izq. ☐ Mano / Muñeca Der. ☐ Mano / Muñeca Izq. ☐ Rodilla Der. ☐ Rodilla Izq. ☐ Tobillo / Pie Der. ☐ Tobillo / Pie Izq. ☐ Abdomen. ☐ Mandíbula Der. ☐ Mandíbula Izq.

Explique:____
____
____
____

Frecuencia: ☐ Constante. ☐ Ocasional. ☐ Intermitente ☐ Frecuente.

Progresión del Dolor: ☐ Igual ☐ Empeorando ☐ Mejorando ☐ Fluctuando

Característica: ☐ Molestia ☐ Agudo ☐ Quema ☐ Sordo ☐ Pulsátil. ☐ Cuchillo ☐ Espasmo ☐ Irradia Pierna / Brazo

Severidad: Escala de Dolor: Marque con una X el número que corresponda a tu dolor

Sin Dolor	0	1	2	3	4	5	6	7	8	9	10	**Dolor Intenso**

--------Leve-------- --------Moderado-------- -------Severo--------

Síntomas Adicionales ☐ Mareo ☐ Nausea ☐ Ansiedad ☐ Perdida Olfato ☐ Irritabilidad ☐ Depresión ☐ Confusión ☐ Dolor detrás de ojos ☐ Dificultad Respiratoria ☐ Dificultad al Dormir ☐ Perdida Sabor ☐ Visión Borrosa ☐ Concentración dificultosa ☐ Ruidos en Oídos ☐ Adormecimiento de Brazos Der o Izq. ? ☐ Adormecimiento de Piernas Der o Izq.?

HISTORIA FAMILIAR

Marque con una X si alguno de sus familiares (padres, hermanos, tíos, etc.) sufre o sufrió de:

Cancer	☐	Epilepsia	☐	Arthritis	☐	Enfermedad Riñones	☐
Tuberculosis	☐	Demencia	☐	Hemophilia	☐	Hypertension	☐
Diabetes	☐	Gota	☐	Asma	☐	Enfermedad Corazón	☐

HISTORIA PERSONAL

Cirugias :☐ (Describa) ____

Hospitalización: ☐ (Describa)____

Medicamentos que está tomando :____
____

Accidente carro: Si ☐ No ☐ Cuando?: ____

Alergias: Yes ☐ No ☐ Fuma?: Si ☐ No ☐ Ocasionalmente ☐ Frecuentemente ☐

¿Toma bebidas alcohólicas? Si ☐ No ☐ Ocasionalmente ☐ Frecuentemente ☐

GENERAL

Marque el mas apropiado

	Pasado	**Presente**		**Pasado**	**Present**
Dolor de Cabeza	☐	☐	Accidente Trabajo	☐	☐
Hemofilia	☐	☐	Enfermedad Venerea	☐	☐
Problemas siquiatricos	☐	☐	Bulimia / Anorexia	☐	☐
Enfermedad Tiroides	☐	☐	Dependencia a las Drogas	☐	☐
Depresion	☐	☐	Mareo	☐	☐

	Past	**Presente**		**Pasado**	**Presente**		**Past**	**Present**		**Pasado**	**Present**
Asma	☐	☐	Cancer	☐	☐	Artritis	☐	☐	Anemia	☐	☐
Epilepsy	☐	☐	Diabetes	☐	☐	Tuberculosis	☐	☐	Hepatitis	☐	☐
Fiebre	☐	☐	Gota	☐	☐	Sida	☐	☐	Vitamins	☐	☐

PIEL

Psoriasis	☐	☐	Eczema	☐	☐	Dermatitis	☐	☐	Herpes	☐	☐

HISTORIA CLINICA

EENT	Past	Present		Past	Present		Past	Present
Glaucoma	☐	☐	Problemas visuales	☐	☐	Otitis	☐	☐
Cataratas	☐	☐	Ruido Oidos	☐	☐	Sinusitis	☐	☐
Conjuntivitis	☐	☐	Perdida Audicion	☐	☐	Sangrado Nariz	☐	☐
Rinitis	☐	☐	Tos Persistente	☐	☐	Ronquera	☐	☐

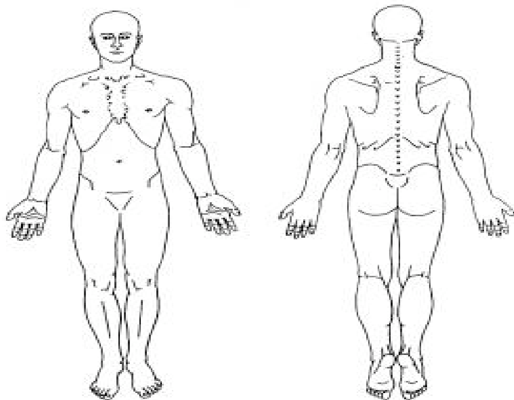
	Past	Present
CARDIOVASCULAR - RESPIRATORIO	☐	☐
Hypertension Arterial	☐	☐
Dolor en el Pecho	☐	☐
Infarto Cardiaco	☐	☐
Enfermedad Corazon	☐	☐
Fiebre Reumatica	☐	☐
Soplo Corazon	☐	☐
Hinchazon en tobillos	☐	☐
Dificultad al respirar /caminar / dormir	☐	☐
Tos Cronica	☐	☐
Expectorando Flema	☐	☐
Escupiendo Sangre	☐	☐
Neumonia	☐	☐
Bronquitis	☐	☐
___________________________________		

	Past	Present
GASTROINTESTINAL - G / U	☐	☐
Enfermedad del Higado	☐	☐
Ulcera	☐	☐
Perdiada del Apetito	☐	☐
Flatulencia (Gas)	☐	☐
Vomito, Nausea	☐	☐
Dolor Abdominal	☐	☐
Calculos biliares	☐	☐
Hemorroides	☐	☐
Constipacion	☐	☐
Hernia	☐	☐
Ictericia	☐	☐
Calculos Renales	☐	☐
Infeccion Urinaria	☐	☐
Sangre en la Orina	☐	☐
Dificultad ☐al Orinar☐	☐	☐

REPRODUCTIVO	Past	Present
Embarazada	☐	☐
Menstruaciones Irregulares	☐	☐
Test de Papanicolao Anormal	☐	☐
Problemas de la Prostata	☐	☐
Dolor en Testiculo	☐	☐

____

Marque una X en los lugares del dolor



____

____

SISTEMA NERVIOSO Y MUSCULOSKELETAL	Past	Present
Dolor en la Cintura	☐	☐
Dolor en el Cuello	☐	☐
Dolor entre las Escapulas	☐	☐
Dolor en los Brazos	☐	☐
Dolor en la Pierna - Ciatica	☐	☐
Espasmos musculares	☐	☐
Pérdida de fuerza en Manos y/o Piernas	☐	☐
Adormecimiento de Brazos y/o Piernas	☐	☐
Perdida de sensibilidad de Brazos y/o Piernas	☐	☐
Hernia de Disco	☐	☐
Scoliosis	☐	☐
Fracturas / desgarros	☐	☐
Osteoporosis	☐	☐
Pierna mas corta	☐	☐

Previous Simtomas

☐ No he tenido síntomas similares a mi condición actual

☐ He tendido estos síntomas antes pero no me molestaban

☐ Los síntomas anteriores existían, pero se agravaron

Mis síntomas más recientes ocurrieron: _____ ☐ meses atrás

________ ☐ años atrás o en Fecha: _____/_____/_____

Firma: ____ Fecha: ____________________________

Descripción del Accidente Automovilístico

Fecha del Accidente: ______________ **Hora del Accidente:** __________ **Ciudad donde ocurrió:** _____________________

1. Clase de vehículo
☐ Carro ☐ Station Wagon
☐ Van ☐ Pickup truck
☐ Camión grande ☐ Bus
Modelo y año de su Carro: ___________________________

2. Su posición en el vehículo
☐ Chofer ☐ Pasajero adelante
☐ Pasajero atrás (lado izquierdo)
☐ Pasajero atrás (lado derecho)

3. ¿Que estaba haciendo su carro en el momento del accidente?
☐ Parado en intersección ☐ Parado en tráfico ☐ Parado en la luz
☐ Volteando a la derecha ☐ Girando a la izquierda ☐ Parqueado
☐ En movimiento ☐ Disminuyendo velocidad ☐ Acelerando
Modelo y año del otro Carro: _____________________________

4. Velocidad /Daño
Velocidad de su carro: _____mph
Velocidad del otro carro :_____mph

5. Detalles del Accidente
Visibilidad lugar accidente.
☐ Pobre ☐ Aceptable ☐ Buena

6. Condiciones de la carretera
Condiciones de la vía al momento del accidente
☐ Hielo ☐ Mojada ☐ Arenosa ☐ Oscura ☐ Limpia y seca

Daño de su vehículo
☐ Leve ☐ Moderado ☐ Total
Daño del otro vehículo
☐ Leve ☐ Moderado ☐ Total

Quien golpeo a Quien / Que?
☐ Usted golpeo al otro vehículo
☐ El otro vehículo lo golpeo
☐ **Usted golpeo** __________

Sitio de impacto
☐ De frente ☐ Adelante a la Izq. ☐ Adelante a la Der.
☐ Atrás (bumper) ☐ Atrás a la Izq. ☐ Atrás a la Der.
☐ Puerta chofer ☐ Puerta Der. ___________________

7. Posición de su cuerpo, etc.
¿Se dio cuenta del accidente? **Si** ☐ **No** ☐
¿Se preparo para el impacto? **Si** ☐ **No** ☐
¿Tenía puesto el cinturón? **Si** ☐ **No** ☐
¿Tenía puesto el cinturón del hombro? **Si** ☐ **No** ☐

¿Su vehículo tiene recostador de cabeza? Si ☐ **No** ☐
Cual era la posición de su cabecera al momento del impacto?
☐ Nivel alto de cabeza ☐ Nivel bajo de cabeza ☐ Mitad del cuello
En que posición estaba su cabeza al momento del impacto?
☐ Mirando al frente ☐ Volteada a la derecha
☐ Volteada a la izquierda ☐ Mirando hacia abajo

8. Información adicional del accidente / Otros vehículos involucrados en el accidente
____
____
____

9. Durante el accidente:
¿Su cuerpo golpeo el interior de su vehículo? **Si** ☐ **No** ☐
Describa: ____
¿Perdió el conocimiento? **Si** ☐ **No** ☐ Tiempo:_______
¿Las bolsas de aire salieron? **Si** ☐ **No** ☐
¿Cuáles?: ☐ Chofer ☐ Pasajero ☐ Puertas
¿Su asiento se rompió? **Si** ☐ **No** ☐
Que Objectos se soltaron ☐ Gafas ☐ Celular ☐ Comida
al interior del carro? ☐ Nada Otros: ___________
¿Se presento la policía en el lugar? **Si** ☐ **No** ☐
¿La policía hizo un reporte del accidente? **Si** ☐ **No** ☐
¿A quién culpo la policía del accidente? **Usted** ☐ **Otro** ☐

10. Después del accidente:
Síntomas que experimento después del accidente:
1- Dolor en: ☐ Cabeza ☐ Cuello ☐ Mitad Espalda ☐ Cintura ☐ Pecho
☐ Costillas ☐ Hombro Der. ☐ Hombro Izq. ☐ Mano Der. ☐ Mano Izq.
☐ Rodilla Der. ☐ Rodilla Izq. ☐ Tobillo / Pie Der. ☐ Tobillo / Pie Izq.
☐ Abdomen. ☐ Mandíbula Otro _________________
2- **Síntomas Adicionales:** ☐ Mareo ☐ Nausea ☐ Ansiedad
☐ Perdida de olor ☐ Irritabilidad ☐ Depresión ☐ Diarrea
☐ Dolor de ojos ☐ Dificultad al respirar ☐ Dificultad al dormir
☐ Perdida del sabor ☐ Visión Borrosa ☐ Desconcentración
☐ Ruidos oídos ☐ Confusión ☐ Adormecimiento brazos / piernas
Otros: _______________ ¿Cuál? _______________

11. Hospital / Sala de emergencia?
¿A dónde fue después del accidente?
☐ Casa ☐ Trabajo ☐ Emergencia ER. ☐ Medico particular
¿Como llego allí?
☐ Uste mismo manejo ☐ Otra persona ☐ Ambulancia ☐ Policía
¿Tomaron X-Rays? Si ☐ **No** ☐ **Examen sangre? Si** ☐ **No**☐
¿Áreas del cuerpo radiografiadas? _____________________
¿Qué examen de sangre? ____________________________
Las Radiografías mostraron: __________________________
Tratamientos: ☐ Collar cervical ☐ Hielo ☐ Otro: ______
Medicamentos: ____________________________________
¿Qué instrucciones le dieron? _________________________
____

12. Tratamiento:
Escriba nombre doctores que lo han visto:
1. Dr. ___________________ Fecha 1ra visita: ___/___/___
Especialidad: ______________ Radiografías? **Si** ☐ **No** ☐
Tratamiento recibido: __________________________________
Cuantos tratamientos recibió?_____ Está en tratamiento **Si** ☐ **No** ☐
El tratamiento le ayudo? **Si** ☐ **No** ☐
Fecha de la última visita: ___/___/___
2. Dr. ___________________ Fecha 1ra visita: ___/___/___
Tratamiento recibido: __________________________________
Cuantos tratamientos recibió? _____ Está en tratamiento **Si** ☐ **No** ☐
El tratamiento le ayudo? **Si** ☐ **No** ☐
Fecha de la última visita: ___/___/___

Firma: _________________________________ Date _________________

Columbia Pike Chiropractic

Dr. Jaime A. Chica D.C.

5555 Columbia Pike, Suite #201, Arlington, VA 22204
Phone: (703) 379-6300 Fax: (703) 379-4440

FINANCIAL AGREEMENT

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is NOT A SUBSTITUTE FOR PAYMENT. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

IN ORDER TO CONTROL YOUR OUTSTANFING BALANCE, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE AND DEDUCTIBLE AT TIME SERVICE IS REQUIRED.

If this account is assigned to an attorney/or outside agency for collection and/or suit, Columbia Pike Chiropractic shall be entitled to reasonable attorney's fees and for cost collection.

I authorize the release of any information necessary to determine the liability for payment and to obtain reimbursement on any claim.

______________________________ ______________________________
PATIENT SIGNATURE INSURED'S SIGNATURE

____
DATE

INSURANCE ASSIGNMENT OF BENEFITS

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize Columbia Pike Chiropractic to release any information acquired in the course of my medical examination and treatment, including drug use, alcoholism, and HIV positive test results, to my insurance carrier(s) as necessary to process my insurance.

AUTHORIZATION TO PAY BENEFITS:
I hereby authorize my insurance carrier(s) to make payment directly to Columbia Pike Chiropractic for the Chiropractic and/or medical benefits payable for the services rendered.

______________________________ ______________________________
PATIENT SIGNATURE INSURED'S SIGNATURE

____
DATE

5555 Columbia Pike, Suite #201, Arlington, VA 22204
Phone: (703) 379-6300 Fax: (703) 379-4440

PRACTICE'S REQUIREMENTS

The Practice:

(a) Is required by federal law to maintain the privacy of you PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI
(b) Under the Privacy Rule, may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law
(c) Is required to abide by the terms of the Privacy Notice
(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains
(e) Will distribute any revised Privacy Notice to you prior to implementation
(f) Will not retaliate against you for filing a complaint

EFFECTIVE DATE

This Notice is in effect as of 9/23/2013

PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge receipt of a copy of the Notice, and my understanding and my agreement to its terms

____
PATIENT

____
DATE

FOR PRACTICE USE ONLY

Practice Documentation of Good Faith Effort to Obtain Acknowledgement

Patient's acknowledgement of the Notice could not be obtained because:

__Patient refused to sign
__Communication barrier prohibited obtaining acknowledgment
__Emergency circumstances
__Other

Details:

___________________________ ___________________________
Signature of Practice Date

IRREVOCABLE ASSIGNMENT OF BENEFITS, AUTHORIZATION AND LIEN

To Whom It May Concern:

This Irrevocable Assignment of Benefits, Authorization and Lien (this "Assignment") is made by and between ______________________________ ("Patient") and COLUMBIA PIKE CHIROPRACTIC ("Health Care Provider"). With this Assignment, and in consideration of treatment without having to render concurrent payment, Patient, hereby irrevocably transfers sets over and assigns to Health Care Provider all insurance and/or litigation proceeds to which Patient is now or may hereafter become entitled, including those listed below, up to the total amount due and owing the Health Care Provider for services rendered to the Patient by reason of accident or illness, including interest thereon, as well as any other charges that are due or may become due the Health Care Provider, including, without limitation, requested reports, collection costs and expenses and attorney's fees, and Patient further hereby irrevocably authorizes and directs any insurance company and/or attorney to whom an original or copy of this Assignment is provided to withhold from Patient and pay directly to such Health Care Provider such amount(s) from (1) any insurance benefits payable to Patient or on Patients behalf, including, but not limited to, medical payments benefits, No Fault benefits, health and accident benefits, personal injury protection benefits, third-party liability coverage, foundation grants, governmental or agency benefits, worker's compensation benefits or any other insurance proceeds or benefits of any kind which are payable to or on behalf of the Patient, and (2) any litigation proceeds (which may include insurance proceeds) from any settlement, judgment or verdict in Patients favor as may be necessary to fully pay any and all financial obligations owed to the Health Care Provider by the Patient. This Assignment is to be a complete and current transfer of Patients right, title, and interest, separate from any statutory or contractual lien or claim to which the Health care Provider may also be entitled. Patient acknowledges that Health Care Provider has a substantial pecuniary interest in the enforcement of this Assignment.

The Patient further agrees that, in the event the insurance company and/or attorney obligated hereunder to make payments to the Health Care Provider fails or refuses to make payment for the full amount due as set forth above, this Assignment is a full, immediate and complete assignment of all the Patient's rights, title, interest, remedies and benefits in and to the assigned property to the extent of the Health Care Providers total claim amount; therefore, Patient hereby irrevocably and fully assigns and transfers to the Health Care Provider any and all causes of action that Patient might have or that might exist in Patients favor against such insurance company and/or attorney with respect to the assigned property. In addition to the foregoing assignment, Patient hereby authorizes, nominates and appoints as Patients attorney-in-fact any officer of Health Care Provider, to prosecute said causes(s) of action either in Patients name or in the Health Care Providers name and Patient further authorizes the Health Care Provider to compromise, settle or otherwise resolve said claim(s) or cause(s) of action as it sees fit.

In further consideration of the services provided by the Health Care Provider, Patient hereby grants a lien to said Health Care Provider against any and all insurance benefits and litigation proceeds outlined in the first paragraph above which may be payable to or on behalf of the Patient as a result of the injuries or illness for which Patient has been treated by said Health Care Provider. The Patient further agrees that the statute of limitations applicable to Health care Providers right to demand payment from the patient shall be tolled for all reasonable times that negotiations or litigation between third parties and the Patient are ongoing.

Patient hereby acknowledges that Virginia law imposes a lien in the amount of $750.00 upon Patients claim against the individual or entity whose negligence is alleged to have caused Patients injuries.

Notwithstanding the foregoing, the Patient agrees that until the Health Care Provider is paid in full, the Patient shall remain personally and fully responsible for and promises to pay the total amount due the Health Care Provider (including principal, interest, collection costs and attorney's fees of 35%) until fully paid. The Patient further understands and agrees that this Assignment does not constitute any agreement of or consideration for the Health Care Provider to await payments from any source, and in the event the Health Care Provider deems itself in its sole discretion insecure as to the prospect payment, it may demand payments from Patient immediately upon rendering services at its option and proceed to collect same through legal means if necessary.

Patient authorizes the Health Care Provider to release this Assignment and any information pertinent to Patients case to any insurance company, adjuster or attorney to facilitate collection under this Assignment. Patient hereby nominates and appoints any officer of the Health Care Provider as Patient's attorney-in-fact to endorse/sign Patient's name on any and all checks for payment of the services provided to Patient by said Health Care Provider.

In the event that any part or provision of this Assignment shall be determined to be invalid or unenforceable, the remaining parts and provisions of this Assignment which can be separated from the invalid, unenforceable provision shall continue in full force and effect.

Notice regarding the assignment of medical expense benefits is provided in a separate document. I have been presented with and had an opportunity to read the notice. Acknowledged:_________(patient initials)

Witness the following signatures and seal as of the indicated date:

PATIENT	HEALTH CARE PROVIDER
Patients Signature________________________________	Columbia Pike Chiropractic 5555 Columbia Pike, Ste 201, Arlington ,VA 22204
Printed Name___________________________________	
Date_____________ SS#______________________	By:
Witness_____________________________	It's President
	Date______________

Columbia Pike Chiropractic
Dr. Jaime A. Chica D.C.

5555 Columbia Pike, Suite 201
Arlington, VA 22204

Phone: (703) 379-6300
Fax: (703) 379-4440

NOTICE: AUTOMOBILE ACCIDENT PATIENTS
(Addendum to Assignment of Benefits Form)

If you have been in an automobile accident, you may be entitled to payment from your automobile insurance if you have medical expense benefits coverage. By signing this assignment of benefits form, you are giving to your health care provider the right to receive some or all of the payment directly from your automobile insurance company.

If you have health insurance and your healthcare provider is in-network: As long as you provide information necessary to verify your health insurance coverage, the healthcare provider may only bill the amount you owe for any copayment, coinsurance, or deductibles to your automobile insurance and you may be entitled to any remainder of your automobile insurance benefit.

If you do not provide information necessary to verify your health insurance coverage, do not have health insurance, or your healthcare provider is not in your health insurer's provider network, your healthcare provider may bill its full charges to your automobile insurance.

You may want to consult your insurance agent or attorney before signing or initialing this form. **You are not required to sign/initial this form to receive care. However, if you do not sign this form, you will be required to (i) pay any applicable co-pays and deductibles at the time the services are provided and allow us to bill your health insurance company or (ii) pay for all care at the time of service.**

By signing below, I acknowledge that I have read or had the opportunity to read this notice.

Patient Signature:____

Patient Printed Name: ____

Date: ___________________________

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had the opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and I am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts known, is my best interest.

I have read, and or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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.

To be completed by patient:

____
Print Patient's Name

____
Signature of Patient

____
Date Signed

To be completed by doctor or staff:

Name and address of clinic/office:

Linea Chiropractic Center
7730 Herschel Ave #AA
La Jolla, CA 92037

Print name (s) doctor (s) treating this patient:

Patricia Lotufo, D.C.