



Family Chiropractic Center LLC

Date _____

NEW PATIENT REGISTRATION

Name _____ Date of Birth _____
Last First Middle

(Complete Mailing)
Address _____ **
Street Apt# City State Zip

Home Phone # _____ Work Phone # _____

Cell Phone # _____ Email address _____

Please indicate preferred phone contact: Home / Work / Cell

Emergency Contact _____ Relationship _____ Phone# _____

Marital Status M S W D (if different than above) Spouse's name _____ Spouse's Phone# _____

Employer _____ Occupation _____

**Please notify our staff if there is an alternate address / phone number or form of communication that you wish us to contact you by other than your listed information above. Your information will never be sold, shared or distributed.

How did you hear about us? Referral | Internet search: Google, Bing! Yahoo | Insurance | Other
If referral, who may we thank? _____

Do you have a music preference for your visits? _____

Is this visit routine/accident/illness/other: _____ If Accident (date) _____

Insurance and Payment Information

Do you intend to use health insurance? Yes No

Are you covered by Medicare? Yes No

Are you covered by Medicaid? Yes No

Insurance Information: Ins. Company _____

Policy holder name/Date of Birth/Relation (if different than above) _____

Insurance ID# _____ Group ID# _____ Copay? _____

Claim # _____ (auto accident / worker's compensation only) Adjuster Name _____

PLEASE COMPLETE OTHER SIDE

ACKNOWLEDGEMENT AND UNDERSTANDING

Please initial each item below.

1. _____ I hereby authorize City Fit Family Chiropractic Center LLC and the doctors on staff to provide Chiropractic and other necessary health care services for me as they deem appropriate.
2. _____ I understand and agree that all services rendered to me at this office are my responsibility, regardless of insurance coverage. I have read and signed the clinic financial policy and understand that even if submitted to insurance, I am ultimately personally responsible for payment.
3. _____ If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collections.
4. _____ Email: Email is not to be used for appointment scheduling, sensitive and/or urgent matters. Reply times will depend on when email is accessed and can range from one to several days. Please be aware that Dr. Herrst may not access email while on vacation. Email may entail some privacy risks and is not HIPAA compliant. If you choose to communicate by email, you accept this risk. Please be concise; if Dr. Herrst cannot answer you very briefly, the matter is probably more complicated and should be addressed at the next office visit. If you choose to communicate by email, Dr. Herrst reserves the right to charge a consultation fee for these services if necessary.
5. _____ I authorize release of my patient records to third parties requiring these records for determination of financial liability and/or for the coordination of care with other medical care providers. I can revoke this authorization by submitting a written notice to Andrea L Herrst, DC, c/o City Fit Family Chiropractic Center LLC, 319 SW Washington St, Suite 1001, Portland OR 97204.
6. _____ I authorize release of my personal health records (including chart notes, x-rays, examination forms, et al) to Andrea L Herrst, DC and City Fit Family Chiropractic Center LLC, for purposes of coordinating and informing my treatment while under care in this office. I can revoke this authorization by submitting a written notice to Andrea L Herrst, DC, c/o City Fit Family Chiropractic Center LLC, 319 SW Washington St, Suite 1001, Portland OR 97204.

By signing this application I affirm that I have given true and complete information.

Dated this _____ day of _____ 20_____.

Patient Signature

AUTHORIZATION TO TREAT A MINOR

As a parent or legal guardian, I hereby authorize treatment for the following:

Patient's full name

DOB _____

to any chiropractic or other appropriate treatment deemed appropriate for the above named minor.

Signature _____ Witnessed by _____

CURRENT COMPLAINTS

Name: _____ DOB: _____ Date: ____ / ____ / ____

Where is your current pain/problem? _____

Does your pain spread to another area? (circle all that apply)

Neck Mid-Back Low Back Arms Legs Shoulder Head Other _____

When did you first notice your current problem? _____

What caused the problem/pain: MVA Work Related Trauma Unknown Other _____

When did you notice it most recently? _____

Has this happened before? _____ When was the last time? _____

If this has happened before, how does the current episode compare? same not as bad worse

If this has happened before, did you get it treated? Y / N

Does it disturb your sleep? Y / N Difficult to fall asleep Wakes me up

Are your symptoms: constant or do they come and go? (circle)

Is there a time in the day when symptoms are the worst? AM Middle of the Day PM Other _____

Please describe the quality of your pain/problem (circle all that apply)

Sharp Dull Tingling Achy Numb Stabbing Burning Other _____

What makes it better? _____

What makes it worse? _____

What is your CURRENT pain severity?

(none) 0 1 2 3 4 5 6 7 8 9 10 (worst)

What is your pain on AVERAGE?

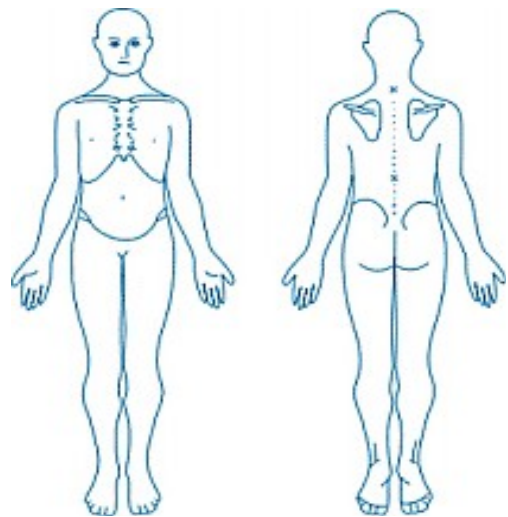
(none) 0 1 2 3 4 5 6 7 8 9 10 (worst)

What is your pain at its WORST?

(none) 0 1 2 3 4 5 6 7 8 9 10 (worst)

Please mark areas of your current complaint on the chart to the right, using the key below.

ACHE >>> Burning XXX
STABBING /// PINS AND NEEDLES 000
NUMBNESS === THROBBING]]]



Patient Signature

Date

Clinician Signature / Date

last updated 4/12

PERSONAL HEALTH HISTORY

Patient's Name _____ DOB _____ Date _____

All information will be kept strictly confidential. Your responses will help determine if chiropractic treatment will benefit you. Unless we sincerely feel that your condition will respond satisfactorily, we will not recommend treatment. Please check the degree of all conditions you currently have or have had. To be responsible for your case, we need your complete health history.

O = Occasional F = Frequent C = Constant

<p>O F C Muscle / Joint <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Arthritis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bursitis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Foot trouble <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hernia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Low back pain <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lumbago <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Neck pain, stiffness <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain between shoulders</p> <p>General <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Allergy <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chills <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Convulsions <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dizziness <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fainting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fatigue <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fever <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Headache <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Loss of sleep <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Loss of weight <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nervousness, depression <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Neuralgia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Numbness <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sweats <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tremors</p> <p>Cardiovascular <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hardening of arteries <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> High blood pressure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Low blood pressure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain over heart <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor circulation <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Rapid heartbeat <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Slow heartbeat <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Swelling of ankles</p> <p>Genitourinary <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bed-wetting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Blood in urine <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent urination <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lack of kidney control <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Kidney infection <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful urination <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Prostate trouble <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pus in urine</p>	<p>O F C Eye, Ear, Nose and Throat <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Asthma <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Colds <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Crossed eyes <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Deafness <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dental decay <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Earache <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ear discharge <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ear noise <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Enlarged glands <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Enlarged thyroid <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Eye pain <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Failing vision <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Far sightedness <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Gum trouble <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hay fever <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hoarseness <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nasal obstruction <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Near sightedness <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nose bleeds <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sinus infection <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sore throat <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tonsillitis</p> <p>Gastrointestinal <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Belching or gas <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Colitis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Colon trouble <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Constipation <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diarrhea <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Difficult digestion <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bloating abdomen <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Excessive hunger <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Gallbladder trouble <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Intestinal worms <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Jaundice <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Liver trouble <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nausea <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain over stomach <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor appetite <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vomiting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vomiting of blood <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hyperglycemia</p>	<p>O F C Skin <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Boils <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bruise easily <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dryness <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hives or allergy <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Itching <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Skin eruptions (rash) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Varicose veins</p> <p>Pain or numbness in <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Shoulders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Arms <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Elbows <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hand <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hips <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Legs <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Knees <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Feet <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful tailbone <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor posture <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sciatica <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spinal curvature <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Swollen joints</p> <p>Respiratory <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chest pain <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chronic cough <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Difficult breathing <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spitting up blood <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spitting up phlegm <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Wheezing</p> <p>Women only <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Congested breasts <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cramps or backache <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Excess menstrual flow <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hot flashes <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Irregular cycle <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lumps in breast <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Menopause <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful menstruation <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vaginal discharge</p> <p>Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many months? _____ How many children do you have? _____</p>	<p><i>Check any of the following conditions you currently have or have had:</i></p> <p><input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Appendicitis <input type="checkbox"/> Arteriosclerosis <input type="checkbox"/> Cancer <input type="checkbox"/> Chicken pox <input type="checkbox"/> Cholera <input type="checkbox"/> Cold sores <input type="checkbox"/> Diabetes <input type="checkbox"/> Diphtheria <input type="checkbox"/> Eczema <input type="checkbox"/> Edema <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Fever blisters <input type="checkbox"/> Goiter <input type="checkbox"/> Gout <input type="checkbox"/> Heart disease <input type="checkbox"/> Herpes <input type="checkbox"/> Influenza <input type="checkbox"/> Lumbago <input type="checkbox"/> Malaria <input type="checkbox"/> Measles <input type="checkbox"/> Miscarriage <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Mumps <input type="checkbox"/> Pacemaker <input type="checkbox"/> Pleurisy <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polio <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Scarlet fever <input type="checkbox"/> Stroke <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Typhoid fever <input type="checkbox"/> Ulcers <input type="checkbox"/> Venereal disease <input type="checkbox"/> Whooping cough</p>
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Have you seen a chiropractor before? Yes No If yes, how long ago? _____ Who? _____

Have you seen a massage therapist before? Yes No Depth/Pressure preference _____

Other Physician/Provider Name & Phone Number _____

Patient name: _____ **DOB:** _____ **Date:** _____

Have you been hospitalized in the last 5 years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, explain.
Have you had any mental or emotional disorders?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, when?
List all current medications/supplements/vitamins:			
Height _____	Current Weight _____	Highest Weight / When? _____	
What is the age of your mattress?	Is it	<input type="checkbox"/> comfortable?	<input type="checkbox"/> uncomfortable?
		Age of your pillows?	
How is most of your day spent?	<input type="checkbox"/> standing	<input type="checkbox"/> sitting	<input type="checkbox"/> walking
	<input type="checkbox"/> other (specify)	Occupation:	

Have you ever:	Yes	No	If yes, briefly explain.
- had a broken bone?	<input type="checkbox"/>	<input type="checkbox"/>	
- had strains or sprains?	<input type="checkbox"/>	<input type="checkbox"/>	
- used a cane, crutch or other support?	<input type="checkbox"/>	<input type="checkbox"/>	
- been struck unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	
- had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	
- been in a motor vehicle accident?	<input type="checkbox"/>	<input type="checkbox"/>	
- had a major injury or illness other than MVA?	<input type="checkbox"/>	<input type="checkbox"/>	

Do you:	Yes	No		Yes	No	How often?
- take minerals, herbs or vitamins?	<input type="checkbox"/>	<input type="checkbox"/>	-Drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	
- have any drug or other allergies?	<input type="checkbox"/>	<input type="checkbox"/>	-Smoke or chew tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	
- take over-the-counter pain medications?	<input type="checkbox"/>	<input type="checkbox"/>	-Exercise?	<input type="checkbox"/>	<input type="checkbox"/>	
- wear your seatbelt?	<input type="checkbox"/>	<input type="checkbox"/>	- Drink caffeinated beverages?	<input type="checkbox"/>	<input type="checkbox"/>	

When did you last have:	Never	0-6 mos.	6 -18 mos.	longer
- spinal examination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- physical examination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- spinal x-ray?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- CT scan / MRI?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please list any other health conditions you have been treated for, or surgery you have had, in the last ten years.

FAMILY HEALTH HISTORY: Information about your immediate family members, brothers, sisters, parents, and grandparents will give us a better understanding of your total health picture.

RELATIONSHIP	PRESENT AND PAST HEALTH PROBLEMS

FINANCIAL POLICY

We share the concern of our patients about the increasing cost of medical care. Our fees are comparable to the usual and customary charges made by like specialists in the area. These charges are based on cost, time and skill involved.

Patients without insurance coverage are requested to pay their charges at the time service is provided. Patients with insurance coverage are responsible for that portion of the estimated charges not covered by the insurance company. Cash, Check, Visa or Mastercard may be used for payment. Please ask for an estimate of the charges at the time of your examination.

Our Policy on Insurance

Please remember that insurance estimates are based on information provided by you and your insurance company. The amount of insurance coverage is an estimate only and may not reflect what your insurance carrier will actually pay.

We will gladly discuss your treatment with you and answer any questions relating to your insurance. We will also assist you in collecting your insurance benefits, however, you must realize that:

1. Your insurance is a contract between you or your insurance beneficiary (usually a family member), your employer and the insurance company. We are not a party to that contract.
2. Not every service is a covered benefit with all insurance contracts. Some insurance companies are selective in what services they cover.
3. Services cannot be provided on the assumption that the charges will be paid by the insurance company, therefore, **the patient is responsible for the bill, regardless of insurance coverage.**

There is no interest or finance charge on current accounts. After 90 days, all accounts are subject to a Finance Charge of 1.75% of the unpaid balance (or a minimum charge of 50 cents), which is an Annual Percentage Rate (APR) of 21%. If a payment from



your insurance company results in a credit balance, a refund will be promptly sent to you.

Notice of Policy on Missed or Late Cancellation of Appointments

Our office requires 24 hours notice for cancellation/ rescheduling of all appointments. There will be a \$15.00 charge to the patient, for which they are personally responsible, for all appointments that are missed and not canceled 24 hours or more before the scheduled appointment time. Patients are eligible for one (1) excused absence without charge every six months, starting from the month the patient begins care. Excused absences are not banked and do not roll-over.

I hereby assign to Andrea L Herrst, DC and City Fit Family Chiropractic Center LLC, the insurance benefits which are otherwise payable to me for her charges and direct that insurance payments be made directly to the office. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as an original. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize assignee to release all information necessary to secure the payment.

Signature of Responsible Party: _____

Date: _____



INFORMED CONSENT

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include mild, local discomfort in the area adjusted for several hours to several days following an adjustment, sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care in this office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I, the undersigned, hereby consent to the performance of chiropractic adjustments and other chiropractic procedures, on myself (or on the patient named below for whom I am legally responsible) by **Andrea L Herrst, DC**, and/or other licensed practitioners who now or in the future provide chiropractic adjustments and other types of treatment for me. This consent includes other doctors of chiropractic, chiropractic assistants and licensed massage therapists that are employed by, associated with or serve as back-up for **Andrea L Herrst, DC**, whether or not their names are listed on this form.

I understand and consent to the following procedures: examination, x-rays (if needed), neck, spine and extremity adjustments, joint mobilization, massage therapy, soft-tissue therapies, instrument assisted soft tissue therapy, electrical muscle stimulation, physical therapies, hot/cold therapies, traction and/or other procedures recommended for my condition(s).

I have had an opportunity to discuss with **Andrea L Herrst, DC** the various types of treatment, including spinal adjustments, instrument assisted soft tissue therapy, myofascial release and joint mobilization, which have been proposed to me for my condition and the purpose and objectives of these procedures. I understand that the results from the treatment are not guaranteed for my condition.

I understand and have had the opportunity to ask about risks and benefits to the proposed treatment and have been informed of other alternative types of treatment for my condition.

I have had the opportunity to read this form, understand the above statements, accept the risks mentioned and hereby consent to chiropractic treatment over the entire course of treatment for my present condition and any future conditions for which I seek treatment.

PATIENT NAME (PRINT): _____ **DATE:** _____

X _____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

NAME: _____ **RELATIONSHIP:** _____

Indicate your name and relationship (parent/guardian/personal representative) if signing for patient (minor).



OFFICE/WITNESS SIGNATURE: _____ DATE: _____

PRIVACY PRACTICES PATIENT RECEPTION FORM

I have received or reviewed the privacy practice notice (5 pages) for City Fit Family Chiropractic Center LLC, and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially applied for care at this office (my New Patient Registration) on my first visit, whenever that may have occurred.

I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in the privacy practices statement.

Patient Signature

Date