CORNERSTONE
CHIROPRACTIC

Office Policies

1. Please be on time for your appointment. Being late, or last-minute cancellations will cause severe scheduling disruptions, which can interfere with the quality of care you and other patients receive.
2. The doctor will recommend a specific care plan for you. You are expected to follow the care plan. If you foresee difficulty following the care plan, please discuss it with the doctor prior to starting care. A certain number of visits in a set amount of time is required for us to get the results we both desire.
3. Children are welcome here as patients. If you bring children with you for your appointment you are responsible for their actions at all times. Please have them accompany you to the adjusting room for your adjustment.
4. If you need to spend extra time discussing your health concerns with the doctor, please let our staff know prior to your appointment, so we may schedule accordingly.
5. Please notify your doctor of any changes in your health status, regardless of the significance.
6. Walk-in patients are always welcome, however, patients with scheduled appointments will be seen first.
7. Payments and co-pays are expected at the time services are rendered.
8. The patient is financially responsible for all services rendered to them in our clinic, regardless of insurance payment.
9. It is the patient's responsibility to verify insurance benefits and notify the front desk of any changes in insurance benefits. When we speak to insurance companies, we are not always given correct or up-to-date information. We are not responsible for incorrect information given by your insurance company. The best way to verify information is by consulting your written insurance policy.

Terms of Acceptance • Informed Consent of Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after bring advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship ay affect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction of may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care, we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommended that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Print Name	Signature	Date

Consent to Treat Minor

I, _____, being the parent or legal guardian of _____ have read and fully understood the above terms of acceptance and hereby grant permission for my child to receive chiropractic evaluation (including x-rays) and care or massage therapy.

Signature	Date

Pregnancy Release

This is to certify that to the best of my knowledge that I am not pregnant and I have been advised that x-rays can be hazardous to an unborn child.

Signature	Date

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Date:_____

Chiropractic Intake Form

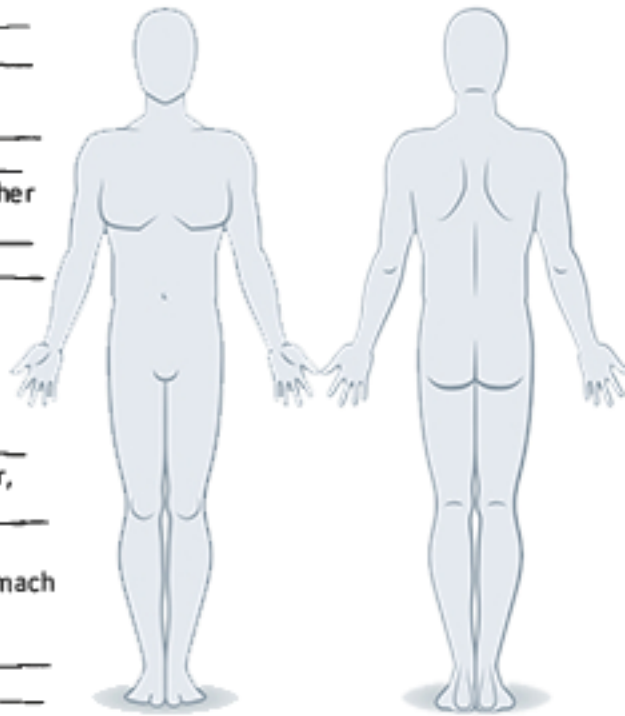
Name: _____ Cell: _____
Address: _____ Unit# _____ City _____ Zip _____
DOB: _____ Age
Occupation: _____ ☐ Full Time ☐ Part Time ☐ Student ☐ Unemployed
Employer: _____ ☐ Single ☐ Married ☐ Divorced ☐ Other
Email: _____
Emergency Contact: _____ Cell: _____ Relationship: _____
Social Security No:
How did you hear about us? ☐Online (Google, Facebook, etc.) ☐Recommended by Friend ☐Other:_____

Have you been treated by a chiropractor before? ☐Yes ☐No
If yes, Doctor's Name/Facility: _____
Reason for Care: _____
Date of last chiropractic visit: _____
Have you had x-rays in the past two years? ☐Yes ☐No
Date of last chiropractic x-rays: _____
How long were you under care? _____
Reason for this visit: ☐ Auto Accident ☐ Employment Accident ☐ Other
List past surgeries and dates: _____
List past accidents/traumas and dates: _____
Please indicate any of the following that apply to you:

☐ Cancer	☐ Heart Attack/Stroke	☐ Muscle Spasms
☐ Diabetes	☐ Sprains/Strains	☐ Fibromyalgia
☐ Arthritis	☐ Joint Replacement(s)	☐ Scoliosis
☐ Numbness	☐ Headaches/Migraines	☐ Other: _____

What do your daily work habits include? (Ex. Sitting, standing, light labor, heavy labor, computer work, etc): _____

Please circle any areas of discomfort:



Do you sleep on your: ☐ Back ☐ Right side ☐ Left side ☐ Stomach
Do you exercise? ☐ Yes ☐ No
What type of exercise? _____
How frequent? _____

Insured Patient ☐ By checking this box, I certify that I, and/or my dependents, have insurance and assign directly to Cornerstone Chiropractic all benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I understand that 'copays' are payable at the time of each visit and that I am financially responsible for all charges whether or not paid by insurance. The above-named providers office may use my healthcare information and may disclose such information to the insurance company and their agents for the purpose of obtaining payment for services and determining benefits payable for related services.
It is the patient's responsibility to verify insurance benefits and notify the front desk of any changes in insurance benefits. When we speak to insurance companies, we are not always given correct or up-to-date information. We are not responsible for incorrect information given by your insurance company. The best way to verify information is by reviewing your written insurance policy.

Private Pay/Cash Rate ☐ By checking this box, I acknowledge that I do not have insurance coverage and I clearly understand and agree that I am personally responsible for payment of any services rendered to me and charged directly to me.

Signature of person responsible for this account

Printed Name

By signing above, you agree to the following:
I have completed this form to the best of my ability and knowledge and agree to inform the office if any of the above information changes at any time.