South Lake Chiropractic

24000 Highway 7
Shorewood, MN 55311
952-474-2395

NEW PATIENT ADMITTANCE
CONFIDENTIAL INFORMATION
ALL INFORMATION IS REQUIRED

Today's Date: _____

LEGAL LAST NAME	LEGAL FIRST NAME	LEGAL MIDDLE

Address

City	State	Zip Code

Home Phone	Work Phone	Cell Phone

Sex Male ____ Female ____	Age	Date of Birth		Marital Status

Who referred you?

***** IF PATIENT IS A MINOR, PLEASE FILL OUT PARENT/GUARDIAN INFORMATION BELOW*****

Father	Employer	Business Telephone
Mother	**Employer**	**Business Telephone**

A monthly fee of 1.5% will be added to any account balance over 30 days old.

Records Released to Insurance Carriers and Other Payors: I hereby authorize South Lake Chiropractic to release to my insurance company, health plan, no-fault carrier, and/or workers' compensation carrier, any information (including my complete health records) needed to determine benefits for services provided by or on behalf of South Lake Chiropractic.

I understand that I am financially responsible for all charges.

HIPAA: I have been informed of South Lake Chiropractic privacy practice by being offered a copy of the policy, which is available at the front desk. This acknowledgement is required under the Health Insurance Portability and Accountability Act of 1996, of "HIPAA".

_____ _____

Patient Signature Date Signed

Turn over for Disclosure and Consent Information

South Lake Chiropractic

DISCLOSURE AND CONSENT
CHIROPRACTIC CARE

You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other chiropractic procedures to be used so that You may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I hearby 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).

I have had the opportunity to discuss with my physician, my diagnosis, the nature and purpose of chiropractic adjustments and other procedures and alternatives.

I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. 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 on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any further condition(s) for which I seek treatment.

PRINTED NAME

PATIENT SIGNATURE DATE

WITNESS (Doctor or Staff) DATE