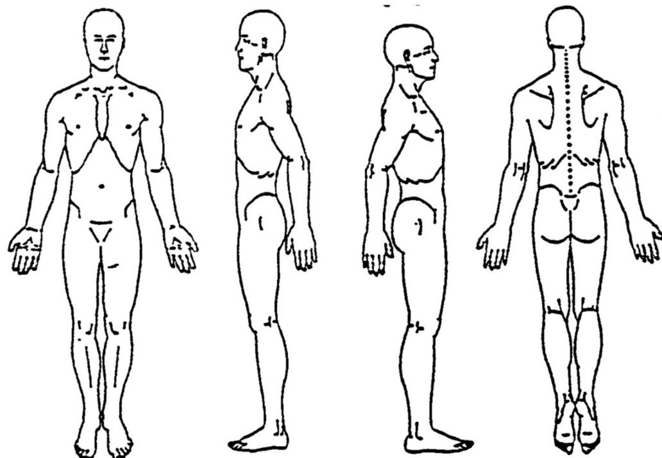
Chiropractic Health Services, PC
3 Pierces Rd, Newburgh, NY 12550

ph: 845-561-6800
fx: 914-885-1091

Patient Name: ______________________________________
Last ***First***

* *



< Mark the man where you have pain.

ANALOG SCALE
1 2 3 4 5 6 7 8 9 10
best worst

PAIN TYPE:
Sharp Achy Dull Tense
Burning Throbbing Stiff
Stabbing Numb Tingling
Pinching
Other_________________

FREQUENCY:
Intermittent (25% of the time)
Occasional (25-50% of the time)
Frequent (50-75% of the time)
Constant (75-100% of the time)

Use this space for any additional information you wish to discuss;
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PRIVACY PRACTICES

I have read the privacy practice notice for Newburgh Chiropractic, and understand the situations in which this practice may need to utilize or release my medical records. 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 X_____________________________________

CHIROPRACTIC CONSENT TO TREAT

In the course of chiropractic healthcare, it is essential for the physician and the patient to work toward the same objectives. As a patient it is important to understand the goals and methods of chiropractic that will be used in order to avoid confusion or disappointment.

Subluxation is fixation of one or more vertebrae of the spinal column. This subluxation can cause alteration of the function of nerves and interfere with transmission of nerve impulses. Alteration of nerve impulses can interfere with the body's ability to achieve maximum health potential. Health is a state of optimal physical, mental and social well being.

The chiropractic adjustment is the specific application of forces to facilitate the correction of a vertebral subluxation. Chiropractic is a “hands-on” approach to patient wellness.

We do not offer to treat any disease or condition other than vertebral subluxation and resulting spinal dysfunction (muscle spasm, nerve irritation, etc) during the course of examination or treatment. If findings occur outside the chiropractic scope of practice, we will advise you and recommend or refer you to a health care provider that specializes in that area.

My chiropractic physician has responded to my questions and requests for information, and has explained the proposed treatment, alternatives, benefits and some of the risks of treatment. I have read or had read to me, the above consent and fully understand the above statements. By signing below, I consent to chiropractic treatments.

PATIENT SIGNATURE X_____________________________________

NON-COVERED SERVICES

Under your health plan, you are responsible for co-pays, co-insurance, and deductibles for covered services, as well as those services that exceed benefit limits. You are also responsible for all non-covered services as defined by your health plan contract. For example, this may include items such as vitamins, supplements, orthotics, and other durable medical equipment. We make every effort to inform you when services are not covered by your insurance. Your acknowledgment below indicates that you have been advised of this information and that you agree to pay for the services or products not covered by your insurance.

PATIENT SIGNATURE X_____________________________________