

Patient Information

Today's Date: _____

Last Name: _____

First Name: _____ M.I. _____

Address _____

City _____ State _____ Zip _____

Email _____

Sex ☐ Male ☐ Female Age _____

Birthday: _____

Patients SS#: _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Occupation: _____

Employer/School: _____

Employers Address: _____

City _____ State _____ Zip _____

Employer/School Phone: _____

Whom may we thank for referring you? _____

Phone Numbers

Home Phone (____) _____

Cell Phone (____) _____

Appointment Reminder- **Email, Text or Phone Call?**

Cell Phone Carrier – **VZW- Sprint- ATT- Metro- T-Mobile**

Other _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (____) _____

Accident Information

Is condition due to an accident? ☐ Yes ☐ NO

Date _____

Type of accident ☐ Auto ☐ Work ☐ Home

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Work Comp ☐ Other

Attorney Name (if applicable) _____

List of Medications/Vitamins

Exercise

☐ None

☐ Moderate

☐ Heavy

☐ Daily

Habits

☐ Smoking

☐ Alcohol

☐ Coffee/Caffeine Drinks

☐ High Stress Level

Work Activity

☐ Sitting

☐ Standing

☐ Light Labor

☐ Heavy Labor

Packs/Day _____

Drinks/Week _____

Cups/Day _____

Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Allergies

Height: _____

Wt: _____

--Latex --Rubber -- KT tape --NSAID --Soaps --None --Other_____

Surgeries

--Abdominal	--Ablation	--Achilles	--Ankle	--Appendix
--Arm	--Back	--Brian/Tumor	--Breast	--Carpal tunnel
--Cataracts	--Cervical Disc	--Chest	--Colon	--Cornea
Transplant				
--C-section	--Disc	--Diverticulitis	-- Ectopic Pregnancy	--EENT
--Elbow	--Endometriosis	--Femur	--Foot	--Gallbladder
--Gastrointestinal	--Gynecological	--Hand	--Heart	--Heart Bypass
--Hemorectomy	--Hernia	--Hip	--Hip Replacement	--Hysterectomy
--Knee	--Intestine	--Jaw/Orthodontic	--Kidney	--Kidney Stones
--Knee Replacement				
--Lumbar Disc	--Lasik	--Liposuction	--Laparoscopy	--Lithotripsy
--Miscarriage	--Lumpectomy	-- Lymphedema	--Lipoma	--Mastectomy
--Nose	--Mole	--Neck	--Neurological	--NONE
--Prostate	--Obstetrical	--Other	-- Ovary	--Podiatric
--Sinus/Jaw	-- Prostatectomy	--Rhinoplasty	--Scar Revision	--Shoulder
thoracic	--Sleep Apnea	-- Spinal fusion cervical	--Spinal fusion	--Spinal fusion
--Stent			lumbar	
Removal	--Thoracic Disc	--Throat	-- Tonsil/s	--Varicose Vein
--Wrist				
	--Wrist/Hand			
--Other _____				

Medical History

--Alcoholism	--Allergy Shots	--Anemia	--Ankle Pain
--Appendicitis	--Arm Pain	--Arrhythmia	--Arthritis
--Asthma	--Back Pain	--Brachialplexus Palsy	--Breast Lump
--Broken Bones	--Bronchitis	--Cancer	--Carpal Tunnel
--Chemical Dependency	--Chest Pain	--Chicken Pox	--Colon
--Concussion	--Congestive Heart Failure	--Depression/Other disorder	--Diabetes
--Dislocations	--Dizziness	--Elbow Pain	--Emphysema
--Epilepsy	--Eye/Vision Problems	--Fainting	--Falls/Concussion
--Fatigue	--Foot Pain	--Fracture	--Genetic Spinal Disorder
--Goiter	--Gout	--Hand Pain	--Headaches
--Hearing Problems	--Heart Disease	--Hemochromatosis	--Hepatitis
--Hernia	--Herniated Disc	--Herpes	--High Blood Pressure
--High Cholesterol	--Hip Pain	--Jaw Pain	--Join Stiffness
--Kidney Disease	--Kidney Stones	--Knee Pain	--Leg Pain
--Liver Disease	--Low Back Pain	--Lupus	--Measles
--Menstrual Problems	--Mid Back Pain	--Migraines	--Minor Heart Trouble
--Miscarriage	--Mononucleosis	--Multiple Sclerosis	--Mumps
--Neck Pain	--Neurological Disorder	--Neuropathy	--NONE
--Osteoporosis	--Ovarian Cysts	--Pacemaker	--Parkinson's disease
--Pinched Nerve	--Plantar Faciitis	--Pneumonia	--Polio
--Prostate Problems	--Psychiatric Care	--Pulmonary Embolism	--Rheumatic Fever
--Rheumatoid Arthritis	--Scoliosis	--Shingles	--Shoulder Pain
--Significant weight change	--Spinal Cord Injury	--Spondylolisthesis	--Sprain/Strain
--Stomach Problems	--Stroke/Heart Attack	--Thyroid	--Tonsillitis
--Tumor/Growths	--Ulcer/s	--Vaginal Infections	--Vertigo
--Whooping Cough	--Wrist Pain		
--Other _____			

PATIENT: _____

DATE: _____

What body part are you being seen for today:

Is it: Bilateral Left Right

When did condition
start? _____

How did it
start? _____

Do you have any recent imaging (X-ray, MRI, CT, etc.) ? If so please list date and name of facility.

ON A SCALE OF 0-10, WITH 10 BEING UNBEARABLE PAIN, PLEASE RATE YOUR SYMPTOMS:

1 2 3 4 5 6 7 8 9 10

INTENSITY: Minimum Mild Moderate Severe unbearable

NATURE: Dull ache Numbness Radiating pain Sharp Shooting Stabbing Tightness Tingling Throbbing

WHAT HELPS: Acupuncture Chiropractic Heat ICE Massage Nothing Pain Meds Therapy Sleep/rest
Stretching other: _____

FREQUENCY: Intermittent 0-25% of the day Occasional 26-50% of the day Frequent 51-75% of the day
Constant 76-100% of the day

ANY ADDITIONAL COMMENTS:

Activities of Daily Living

Circle each of the activities which you have a difficulty performing and or can perform only with pain.

Bending	Gardening	Personal hygiene/Grooming
Care of others/Pets	General Mobility	Pushing/Pulling with legs/feet
Carrying Objects	Holding onto objects	Pushing/Pulling with hands/arms
Climbing Stairs	Jogging	Reaching out/up/down
Concentrating	Keeping balance	Sitting
Cooking/Cleaning	Housework	Standing
Crouching/ Squatting	Lifting	Turning
Dressing	Lying Down	Twisting
Driving	Moving Joint/s	Walking
Eating	Exercise/Sports	Yard Work
Other Explain: _____		

Please initial:

_____ Please arrive ten minutes before your scheduled appointment time to ensure a full session.

_____ We pride ourselves in not having patients wait and as such need all patients to arrive 10 minutes before their appointment time and no later than their scheduled appointment time. We may have to reschedule your appointment if you are running late.

_____ You may cancel your appointment without charge up to 24 hours preceding your appointment. Same day cancellations will be charged 50% of the scheduled service price. If you do not call to cancel your appointment or do not show up for your scheduled appointment, you will be charged full price for the scheduled service.

_____ Your next _____ visits are for treatment only. In the event that your condition deteriorates, there is re-injury, or new areas need to be addressed please call our office prior to your appointment so we can allow the necessary time for a re-examination by the doctor.

_____ When you arrive at the office we have to first check you into our system before you can sign the sign-in pad.

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENT 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 the 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 an 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 that results are not guaranteed.

I understand and 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, dislocation 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 judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read, 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

To be completed by patient's Representative, if necessary, e.g., if patient is a minor or is physically or legally incapacitated:

Print Patient's Name

Print Name of Patient

Signature of Patient

Print Name of Patient's Representative

Date Signed

Signature of Patient's Representative

To be completed by doctor or staff

Print Name(s) of doctor(s) treating this patient:

Anthony B. Morovati, D.C. and / or
Janine Abramian, D.C. and / or

Morovati Chiropractic Corp
Anthony B. Morovati, D.C.
Janine Abramian-Morovati, D.C.
3515 North Verdugo Rd.
Glendale, CA 91208

Staff Signature: _____

Date: _____

Witness to Patient's _____

Date: _____

This Signed original is to be filed in patient's file and a copy is to be given to the patient.

Patient Name: _____

Financial Policy

Thank you choosing Morovati Wellness Center as your Chiropractic Providers. We are committed to your successful treatment. We request you read, agree to, and sign the following statement of Financial Policy prior to starting treatment.

1. It is your responsibility to verify with your insurance plan/carrier as to your coverage with them. Although we verify your insurance we cannot be held responsible for the information given as insurance companies read a disclaimer that states that verification of benefits is not a guarantee of payment. Please note that Dr Anthony Morovati is not a contracted provider with any insurance company other than Lakeside Medical Group IPA. Please note that Dr Janine Morovati is not a contracted provider with any insurance company. Please verify that service such as office visits, X-Rays and in-office procedures do not require pre-authorization. Some plans require pre-authorization or referrals from the patient's primary care physician. .

2. Payment is due at the time services are rendered, including co-payment and deductibles. Your insurance is billed as a courtesy but it is not a guarantee of payment. We accept cash, check, Visa and MasterCard.

3. Written or verbal authorizations from insurance plans or management groups are not guarantee of payment. All claims are reviewed by the insurance carriers after services are rendered and authorizations can be denied at the time of review. Denied claims become the patient's responsibility. 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 of certain procedures or limit the length of the sessions. Ultimately all charges are your responsibility. Please note that acuscope treatments are time based and are billed in increments of 15 minutes. Furthermore, there is two ways the acuscope can be applied, attended and unattended. When we apply the acuscope attended, we bill for the electric current being applied as well as myofascial release of the trigger points in increments of 15 minutes. When the acuscope is being applied unattended we only bill for the electrical current in increments of 15 minutes. However, keep in mind that the length of time the acuscope is applied is dependent on medical necessity. All supplies, which are not billable to your insurance carrier, must be paid for at the time they are dispensed.

4. Statements are mailed after the insurance company has paid their portion. The account is then payable within 30 days. Overdue accounts are subject to a \$15.00 rebilling fee each 30 days it goes unpaid. Accounts 90 days in rear will be subject to collection and/or interest by and external agency unless financial arrangements are made with our office.

5. APPOINTMENTS THAT ARE NOT CANCELLED WITHIN 24 HOURS TO THE SCHEDULED APPOINTMENT TIME WILL BE CHARGED \$85.00 MISSED APPOINTMENT FEE. PLEASE BE SURE TO ADVISE THIS OFFICE 24 HOURS IN ADVANCE OF CANCELLATION. **We ask that you arrive 10 minutes prior to your appointment time to insure you receive your full session.**

6. Whenever our office refers you to outside laboratories, hospitals, physical therapy or tests, be sure to verify that pre-authorization is not required and that your insurance participates with their facility.

7. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled including Medicare, Private Insurance, and other health plans. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

8. I also acknowledge receipt of the notice of Privacy Practices.

I HAVE READ THE ABOVE AGREEMENT AND AGREE TO THE TERMS AND CONDITIONS AS SET FORTH.

Print name of the financially responsible party _____

SIGNATURE _____ DATE _____

Authorization to Release Medical Records

To: _____

Address _____

—

I, _____ hereby authorize and request you to release to:

Anthony B. Morovati, D.C.
Janine Abramian –Morovati, D.C.
3515 North Verdugo Rd.
Glendale, CA 91208
818-500-8484
818-975-2869 Fax

Any and all records and/or reports in your possession; including history, x-ray results, diagnosis, and treatment concerning my illness of injury of ____/____/____.

Patient's Signature: _____

Date _____

Social Security # _____

Birth Date: _____

CONSENT FOR TREATMENT OF A MINOR

Date: _____

(I) (We) the undersigned, parent (s) or legal guardian (s) of _____, a minor, do hereby authorize, **Anthony B. Morovati, D.C. and/or Janine Abramian, D.C.**, as agents for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician or surgeon licensed under the provision of the Medical Practice Act on the medical staff of any accredited hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of our aforesaid agent (s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable.

This authorization shall remain effective until _____, unless sooner revoked in writing delivered to said agent (s).

Father: _____ Witness: _____

Mother: _____ Witness: _____

Legal Guardian: _____ Witness: _____

COVID-19 INFORMED CONSENT TO TREAT

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

To proceed with receiving care, I confirm and understand the following (Initial in all seven places provided)

**Initial
Below**

- I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted. _____
- I understand that I am opting for an elective treatment that may not be urgent or medically necessary. I understand there are alternatives to receiving this care, which could including receiving care from another type of provider, or postponing care altogether at this time. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. _____
- I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care office. _____
- I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:

*Fever	*Dry Cough	*Sore Throat
*Shortness of Breath	*Runny Nose	*Loss of Taste or Smell

- I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT in the past 14 days I have not traveled: 1) Outside of the United States to countries that have been affected by COVID-19; or 2) Domestically within the United States by commercial airline, bus, or train. _____
- I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care. _____
- I have been offered a copy of this consent form. _____

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Patient	Parent /	Witness
Signature: _____	Guardian	Signature _____
Name _____	Signature _____	Name: _____
Date _____	Name _____	Date: _____
	Date _____	

PATIENT NAME: _____

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California and federal law, and not by a lawsuit or resort to court process except as California and federal law provide for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the healthcare provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the healthcare provider and/or other licensed healthcare providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the healthcare provider, including those working at the healthcare provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the healthcare provider, and/or the healthcare provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's equal share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). The parties further agree that, where not in conflict with this agreement, the Arbitration Rules of ADR Services, Inc. shall govern any arbitration conducted pursuant to this Arbitration Agreement. A copy of the ADR Services rules are available on its website at www.adrservices.com or by calling 213-683-1600 to request a copy of the rules.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the healthcare provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

Patient Name (print): _____ Signature: _____ Date: _____

Parent or Guardian (print): _____ Signature: _____ Date: _____

Office Name: _____ Signature: _____ Date: _____

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures, if indicated. Any examinations or tests conducted will be carefully performed, but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including, but not limited to, hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people, whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE