# Regent Park Chiropractic

Today's date:

## PATIENT INFORMATION

| Patient's last name: First: Middle Initial: | Nickname: | Date of Birth: | Sex: ❑M ❑F |
|---|---|---|---|
| Street address: | Work Phone: | Home Phone: | Preferred Phone: ❑Home ❑Work ❑Cell |
| Address Line 2: | Cell Phone: | Cell Service Provider: | |
| City: | State: | Zip Code: | Email: |

Would you like to receive appointment reminders? Choose ONE:
❑Email ❑Text Message ❑Phone Call ❑None

Preferred Language: ❑English ❑Spanish ❑German ❑French ❑Italian ❑Russian ❑Portuguese ❑Chinese ❑ Japanese ❑Korean ❑Vietnamese ❑Decline to Answer ❑Other _____

Please check ALL races that apply: ❑White ❑Black or African American ❑American Indian or Alaska Native ❑Asian ❑Native Hawaiian/Pacific Islander ❑Decline to Answer

Ethnicity:❑Hispanic or Latino ❑Non-Hispanic nor Latino ❑Declined to Answer

Preferred Communication: ❑Cell Phone ❑Home Phone ❑Work Phone ❑Mail ❑Email ❑In Person

Smoking Status: ❑Current everyday ❑Current some days ❑Former ❑Never Start Year _____ Quit Date _____

Current Medications:
1.Drug Name: _____ Strength (eg. 10MG) _____Dose (e.g. 1 tab)_____
Frequency (e.g. once daily) _____Date Started: _____
2. Drug Name: _____ Strength (eg. 10MG) _____Dose (e.g. 1 tab)_____
Frequency (e.g. once daily) _____Date Started: _____
3. Drug Name: _____ Strength (eg. 10MG) _____Dose (e.g. 1 tab)_____
Frequency (e.g. once daily) _____Date Started: _____

Drug Allergies:
1. Drug Name _____ Reaction (e.g. hives) _____ Date Started: _____
2. Drug Name _____ Reaction (e.g. hives) _____ Date Started: _____
3. Drug Name _____ Reaction (e.g. hives) _____ Date Started: _____

| Referred by: | |
|---|---|

| Alcohol Use: ❑None ❑Light ❑ Moderate ❑Heavy | Drug Use: ❑None ❑Light ❑ Moderate ❑Heavy | Exercise: ❑None ❑Light ❑ Moderate ❑Heavy |
|---|---|---|

## INSURANCE INFORMATION

| Primary Insurance: | Insured ID: |
|---|---|
| Insured Name: | Group Number: |
| Patient is the ❑Spouse ❑Child ❑Self ❑_____ to the insured. | Ins. Date of Birth: |
| Insured Address (if different from patient): | |

| Address 2: | City: | State: | Zip Code: |
|---|---|---|---|
| Deductible? | | Secondary Insurance: | |
| Secondary Insurance: | | Insured ID: | |

## FAMILY HISTORY

Please indicate which conditions exist or have existed by marking the boxes below.

| | Self | Mother | Father | Sister | Brother | Son | Daughter |
|---|---|---|---|---|---|---|---|
| Bone Cancer | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Brain Cancer | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Breast Cancer | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Colon Cancer | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Esophageal Cancer | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Gastric Cancer | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Kidney Cancer | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Leukemia | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Liver Cancer | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Muscle Cancer | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Other Cancer | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Ovarian Cancer | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Pancreatic Cancer | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Prostate Cancer | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Rectal Cancer | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Skin Cancer | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Thyroid Cancer | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Clotting Disorder | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Deep Vein Thrombosis | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Pulmonary Embolism | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Unknown Clotting Disorder | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Dementia/Alzheimer's | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Gestational Diabetes | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Impaired Fasting Glucose | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Insulin Resistance | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Maturity onset Diabetes (MODY) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Pre-Diabetes | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Type 1 Diabetes | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Type 2 Diabetes | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Colon Polyp | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Crohn's Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Familial adenomatous polyposis (FAP) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Gastrointestinal Disorder | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Irritable Bowel Syndrome | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Ulcerative Colitis | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Lynch Syndrome | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Angina | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Coronary Artery Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Heart Attack | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Heart Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Unknown Heart Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Hypertension | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Cystic Kidney Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Chronic Kidney Disease (assoc. Diabetes Type 2) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Congenital Kidney Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Kidney Nephrosis | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Nephritis | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Nephrotic Syndrome | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Other Kidney Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Unknown Kidney Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Asthma | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Nephritis | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Nephrotic Syndrome | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Other Kidney Disease | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Unknown Kidney Disease | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Asthma | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| COPD | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Chronic Bronchitis | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Chronic Lower Respiratory Disease | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Emphysema | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Influenza | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Pneumonia | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Osteoporosis | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Anxiety | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| ADHD | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Autism | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Bipolar Disorder | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Dementia | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Depression | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Eating Disorder | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Mental Disorder | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| OCD | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Panic Disorder | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Personality Disorder | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| PTSD | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Schizophrenia | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Social Phobia | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Septicemia | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Stroke/Brain Attack | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Sudden Infant Death Syndrome | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |

## PATIENT HISTORY

Please describe your past accidents:

1.Accident: _____ ❑Job ❑Auto ❑Other Date: _____

2.Accident: _____ ❑Job ❑Auto ❑Other Date: _____

3.Accident: _____ ❑Job ❑Auto ❑Other Date: _____

Please describe your past surgeries:

1. Surgery: _____ Date: _____

2. Surgery: _____ Date: _____

3. Surgery: _____ Date: _____

Do you have any implants? ❑Yes ❑No If yes, please describe _____

Are you currently pregnant? ❑Yes ❑No If yes, please list your due date: _____

Please indicate which conditions **YOU** (the patient) have experienced by marking the boxes below.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AIDS | ❑ | Allergies | ❑ | Anemia | ❑ | Arthritis | ❑ |
| Asthma | ❑ | Back Pain | ❑ | Bladder Trouble | ❑ | Bone Fracture | ❑ |
| Cancer | ❑ | Chest Pain | ❑ | Concussion | ❑ | Constipation | ❑ |
| Convulsions | ❑ | Depression | ❑ | Diarrhea | ❑ | Dislocated Joints | ❑ |
| Epilepsy | ❑ | Fibromyalgia | ❑ | German Measles | ❑ | Headache | ❑ |
| Heart Trouble | ❑ | Hepatitis | ❑ | Herniated Disk | ❑ | High Blood Pressure | ❑ |
| High Cholesterol | ❑ | HIV/ARC | ❑ | Kidney Disorder | ❑ | Loss of Bowel Control | ❑ |
| Lung Disease | ❑ | Menstrual Cramps | ❑ | Migraine Headaches | ❑ | Multiple Sclerosis | ❑ |
| Muscular Dystrophy | ❑ | Neck Pain | ❑ | Nervousness | ❑ | Numbness | ❑ |
| Osteoporosis | ❑ | Parkinson's disease | ❑ | Pinched Nerve | ❑ | Polio | ❑ |
| Poor circulation | ❑ | Reproductive disorder | ❑ | Rheumatic Fever | ❑ | Rheumatism | ❑ |
| Rheumatoid Arthritis | ❑ | Scarlet Fever | ❑ | Scoliosis | ❑ | Serious Injury | ❑ |
| Sinus Trouble | ❑ | Stroke | ❑ | Thyroid Problems | ❑ | Tuberculosis | ❑ |
| Tumors or Growths | ❑ | Ulcers | ❑ | Venereal Disease | ❑ | _____ | ❑ |

| SYMPTOMS | | | |
|---|---|---|---|
| **On the following pages you will be asked to choose your symptoms from this list.** | | | |
| Neck Pain | Upper Back Pain | Mid Back Pain | Low Back Pain |
| Left Shoulder Pain | Right Shoulder Pain | Left Hip Pain | Right Hip Pain |
| Left Knee Pain | Right Knee Pain | Left Leg Pain | Right Leg Pain |
| Stiff Neck | Headache | Left Hand Pain | Right Hand Pain |

| IMPAIRED ACTIVITIES | | | |
|---|---|---|---|
| **To go with each symptom you are reporting, you will be asked to select the MAIN activity that is made more difficult by each symptom. Choose the activity out of the options below.** | | | |
| Computer Use (extended) | Computer Use (Short time) | Concentrating | Cycling |
| Desk Work | Drawing | Driving | Exercise |
| Lying Down | Piano | Reading | Running |
| Sitting | Standing | Staying Asleep | Using the Phone |
| Walking | Yard Work | Bathing | Bending |
| Caring for Infirm Person | Cervical Range of Motion | Child Care | Climbing Stair |
| Falling Asleep | Dressing | Golf | Hair Care |
| Kneeling | Lifting | Lifting Children | Lifting/Carrying Groceries |
| Looking over Shoulder | Lying Down | Needlework | Pet Care |
| Sexual Activities | Shaving | Sitting | Swimming |

## SYMPTOMS

Please fill out the form below to describe your current symptoms.

### SYMPTOMS

Symptom (choose ONE from list on previous page):

Pain rating (1-10, with 10 being worst imaginable):

❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

Main impaired activity made more difficult by above symptom (choose ONE from list on previous page):

**Pain Quality:**

❑Aching
❑Burning
❑Cramping
❑Deep
❑Diffuse
❑Dull
❑Numbness
❑Radiating
❑Sharp
❑Shooting
❑Stiffness
❑Tight
❑Tingling

**Pain Frequency:**

❑Constant
❑Frequent
❑Intermittent
❑Occasional

**Pain radiates into:**

❑Left Arm
❑Left Foot
❑Left Hand
❑Left Leg
❑Left Shoulder
❑Right Arm
❑Right Foot
❑Right Hand
❑Right Leg
❑Right Shoulder
❑Other:

**Pain Cause:**

❑A Fall
❑Work Injury
❑Auto Accident
❑Illness
❑Lifting Injury
❑Unknown
❑Gradual Onset

**Pain Pattern:**

❑Better in Morning
❑Better in Afternoon
❑Better in Evening
❑Worse in Morning
❑Worse in Afternoon
❑Worse in Evening
❑Consistent
❑Unchanged

**What has been done before to treat this symptom?**

❑Acupuncture ❑ Prescription medicine
❑Massage
❑ Surgery
❑OTC Medicines

**Pain Duration:**

❑_____Day(s)
❑_____Week(s)
❑_____Month(s)
❑_____Year(s)

**Pain aggravated by:**

❑Bending
❑Driving
❑Getting up/down
❑Increased Activity
❑Looking down
❑Overhead activities
❑Reaching
❑Sitting
❑Standing
❑Typing
❑Coughing
❑Exercising
❑House Work
❑Lifting
❑Lying down
❑Preparing food
❑Resting
❑Sneezing
❑Twisting
❑Walking

**Pain relieved by:**

❑Exercise
❑Ibuprofen
❑Knees Bent Up
❑Lying Down
❑No Movement
❑Resting
❑Standing
❑Support
❑Walking
❑Heat
❑Ice
❑Lifting
❑Medication
❑Reaching
❑Sitting
❑Stretching
❑Turning Head

**For Doctor's Use Only:**

What restrictions relate to the main impaired activity for this symptom?

# Regent Park Chiropractic

## PATIENT FINANCIAL RESPONSIBILITY & AUTHORIZATION FORM

Thank you for choosing Regent Park Chiropractic for your chiropractic needs. We are committed to providing you with the highest quality care. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

◦ The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care. ◦ We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance. ◦ Patients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan. ◦ Copays are due at the time of service. ◦ Coinsurance, deductibles and non-covered items are due 15 days from receipt of billing. ◦ Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include:

◦ Charge for returned checks - $30.00

By my signature below, I hereby authorize assignment of financial benefits directly to Regent Park Chiropractic for services rendered. I understand that I am financially responsible for charges not covered by this assignment.

Patient Name _____

Patient/Guardian Signature _____

Date _____

# Reschedule and No-Show Policy

We are committed to improving the health and well-being of our patients and to delivering the best care possible. Part of that commitment is to honor and respect our agreements with you. Our appointment schedule represents an agreement on both our parts. We reserve time for you with the understanding that you will be here at that time. We understand that there are times when you must call to reschedule an appointment due to obligations for work or family. However, when you do not call, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to do the same and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. Remember, the patient in need of that unused time could be you!

And so, we ask for 24-hour notice for rescheduling an appointment.

We understand that in rare cases major life emergencies do come up and we will work with you to accommodate these unfortunate events.

No show appointments will automatically be billed a $25.00 fee.

We also understand that delays can happen. However, if you find that you could arrive after your scheduled appointment time, we ask that you call to tell us so that we can adjust the schedule accordingly.

I have read, understand and agree to the terms of this rescheduling and no show policy.

_____ _____

Print name Date

_____ _____

Patient Signature Date

# REGENT PARK CHIROPRACTIC, LLC

## CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND/OR HEALTHCARE OPERATIONS

NAME _____

DATE OF BIRTH _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. This information is kept private except for uses involved in your healthcare. A copy of the summary of the HIPAA Privacy Rule is available for your review in this office.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and prior health information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that:

- I have the right to object to the use of my health information for directory purposes.
- I have access to a copy of the "Notice of Patient Privacy Rights" and they are available in the office.
- I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations, and that the organization is not required to agree to the restrictions requested.
- I have the right to revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.
- I have the right to request a copy of my records. I understand this requires 48 hours notice.
- I understand that the information used or disclosed pursuant to this authorization may be subject to being disclosed again by recipient and that this information will no longer be subject to protected health information.

I request the following additional restrictions to the use or disclosure of my health information:

_____

I authorize Regent Park Chiropractic, LLC to speak with the following people regarding my healthcare:

_____

With my consent, Regent Park Chiropractic, LLC may call my home or other designated location, and leave a voice message in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and information pertaining to my clinical care.

With my consent Regent Park Chiropractic, LLC may send a narrative to my primary care doctor explaining my evaluation and treatment plan.

PATIENT:

X_____ _____

Signature of Patient/Legal Representative — Date

# Informed Consent

**Patient Name:** _____

Please read this entire Document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

## The nature of the chiropractic adjustment

The primary treatment used by doctors of Chiropractic is spinal manipulative therapy. I will use the procedure to treat you. I may use my hands or mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click" much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

## Analysis/ Examination/Treatment

**Patient should initial each procedure they are consenting to. **

___ Spinal Manipulative Therapy ___ Range of motion Testing ___ Basic Neurological Testing

___ Palpation ___X-ray ___ Muscle Strength Testing ___ Hot/Colds Therapy

____ Orthopedic Testing ____ Postural Analysis Testing _____ Other

## The risk inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and burns. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the doctor.

## The probability of those risk occurring.

Fractures are **RARE** occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. **The most**

**current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is <u>EXTREMELY</u> rare and remote.**

Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

## The availability and nature of the other treatment options.

Other treatment options for your condition may include:

- Self-administered, over the counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

## The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

## Consent to Treatment (Minor)

I hereby request and authorize Dr. Garrett Roy with Regent Park Chiropractic LLC to perform diagnostic tests and render chiropractic adjustments and other treatments to my son/ daughter: _____. This authorization also extends to all other doctors and office staff members of Regent Park Chiropractic LLC.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. (if applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so authorize this care should be revoked or modified in any way, I will immediately notify this office.

**<u>DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW</u>**

**I have read [ ] or have had read to me[ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr Roy or staff at Regent Park Chiropractic and have had me questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that its in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.**

<u>Patients Name:</u> _____ <u>Date</u> _____

Signature: _____

<u>Signature of Parent/Legal Guardian:</u> _____