Welcome

1 About you

TODAY'S DATE: ____/____/____ FILE # _____

PATIENT NAME: _____

LAST FIRST MI

WHAT YOU PREFER TO BE CALLED _____ ❑ MALE ❑ FEMALE

BIRTHDATE: _____ AGE _____ SS# _____

MAILING ADDRESS: _____

_____

CITY STATE ZIP

HOME PHONE #: _____

WORK PHONE #: _____ EXT_____

CELL PHONE #: _____

EMAIL ADDRESS: _____

EMPLOYER: _____ HOW LONG? ____

EMPLOYERS ADDRESS: _____

_____

_____

CITY STATE ZIP

OCCUPATION: _____

STATUS: MINOR SINGLE MARRIED DIVORCED SEPARATED WIDOWED

SPOUSES NAME: _____

DO YOU HAVE KIDS? YES NO HOW MANY _____

2 Insurance Info

CO. NAME: _____

ADDRESS: _____

PHONE#: _____

INSUREDS SS#: _____

GROUP# (PLAN, LOCAL OR POLICY#)

INSURED'S NAME: _____

RELATION: _____

DATE OF BIRTH ____/____/____

INSURED'S EMPLOYER: _____

_____

PLEASE INFORM FRONT DESK OF 2ND. INSURANCE SOURCE

3 REASON FOR VISIT

THE REASON FOR THIS VISIT IS A RESULT OF: (PLEASE CIRCLE): WORK SPORT AUTO TRAUMA OR CHRONIC

(EXPLAIN WHAT HAPPENED): _____

_____

_____

PLEASE DESCRIBE THE PAIN & ITS LOCATION : _____

_____

WHEN DID THIS CONDITION BEGIN? ____/____/____

IS THIS CONDITION GETTING WORSE?

YES NO CONSTANT COMES & GOES

IS THIS CONDITION INTERFERING WITH YOUR: (PLEASE CIRCLE) WORK SLEEP OR DAILY ROUTINE

IF SO PLEASE EXPLAIN : _____

_____

HAVE YOU BEEN TREATED BY A PHYSICIAN FOR THIS CONDITION ? YES NO

IF SO WHERE ? _____

4 IN EVENT OF EMERGENCY

Who should we contact? : _____

Relation : _____

Home phone# : _____ Work phone#: _____

Who is your Medical Doctor? _____ phone#: _____

5 HEALTH HISTORY

Are you taking any of the following medications?

❑ Nerve pills ❑ Pain killers (including aspirin) ❑ Muscle relaxers ❑ Stimulants ❑ Blood thinners ❑ Tranquilizers ❑ Insulin

❑ Others _____

Do you have or ever had any of the following diseases or conditions?

Y N Heart Attack	Y N Heart Surg./Pacemaker	Y N Heart Murmur	Y N Dizziness	Y N Jaw Problems	Y N Leg pain
Y N Congenital Heart Defect	Y N Mitral valve Prolapse	Y N Artificial Valves	Y N Difficulty sleeping	Y N Irritability	Y N Ears ringing
Y N Alcohol/Drug Abuse	Y N Venereal Disease	Y N Hepatitis	Y N Nausea	Y N Back pain	Y N Stomach upset
Y N HIV+/ Aids	Y N Shingles	Y N Cancer	Y N Arm/Shoulder pain	Y N Headaches	Y N Numb Feet/Toes
Y N Frequent Neck Pain	Y N Emphysema / Glaucoma	Y N Anemia	Y N Fatigue	Y N Numb Hands/Fingers	Y N Neck pain
Y N High/Low Blood Pressure	Y N Psychiatric Problems	Y N Rheumatic Fever	Y N Blurred vision	Y N Lower back pain	Y N Memory loss
Y N Severe Frequent Headaches	Y N Kidney Problems	Y N Ulcers / Colitis	Y N Back stiffness	Y N Tension	Y N Arthritis
Y N Fainting/Seizures/Epilepsy	Y N Sinus problems	Y N Asthma	Y N Shortness of breath	Y N Chest pain	Y N Artificial Bones / Joints
Y N Diabetes / Tuberculosis	Y N Difficulty Breathing	Y N Chemotherapy	Y N Neck stiff	Y N Buzzing in ear	Y N Lower Back Problems

Please list any other serious medical condition(s) you have or ever had: _____

Please list anything that you may be allergic to: _____

List previous surgeries / treatments with dates: _____

_____

_____

List any past serious accidents with dates: _____

Family Health History: _____

_____

Do you: Take supplements or vitamins? ❑ Yes ❑ No / Exercise ❑ Yes ❑ No

Are you on a special diet ❑ Yes ❑ No / Since ____/____/____

Do you Smoke? ❑ Yes ❑ No / How much _____ How long _____

Are you wearing Heel Lifts ❑ Sole Lifts ❑ Inner Soles ❑ Arch Supports

For women:

Are you taking Birth Control? ❑ Yes ❑ No

Are you pregnant? ❑ No ❑ Yes / How Long?

Nursing? ❑ Yes ❑ No

■ I AGREE TO PAY FOR SERVICES RENDERED TO THE ABOVE MENTIONED PATIENT AS THE CHARGES ARE INCURRED. I UNDERSTAND AND AGREE THAT HEALTH & ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT OF ANY AND ALL SERVICES COVERED OR NON-COVERED. I ALSO UNDERSTAND THAT IF I SUSPEND OR TERMINATE MY CARE AND TREATMENT, ANY FEES FOR PROFESSIONAL SERVICES RENDERED WILL BE IMMEDIATELY DUE AND PAYABLE. THE INJURIES / ILLNESS SUSTAINED AND THE PAIN AND SUFFERING I HAVE ARE REAL AND I HAVE NOT EITHER IMAGINED OR EXAGGERATED THE EXTENT AND NATURE OF MY PAIN AND SUFFERING OR ILLNESS.

■ I AM OF SOUND MIND, AND TO THE BEST OF MY KNOWLEDGE ALL THE INFORMATION I HAVE PRESENTED IS TRUE. I AUTHORIZE THE STAFF TO PERFORM ANY NECESSARY SERVICES NEEDED DURING DIAGNOSIS AND TREATMENT. I ALSO AUTHORIZE THE PROVIDER AND OR MANAGED CARE ORGANIZATION, TO RELEASE ANY INFORMATION REQUIRED TO PROCESS INSURANCE CLAIMS.

SIGNATURE _____

PAIN CHART

About you

PATIENT NAME: _____ FILE # _____

WHAT IS YOUR CURRENT WEIGHT: _____ LBS, AND HEIGHT _____FT_____IN.

PLEASE DESCRIBE YOUR CONDITION: _____

_____

_____

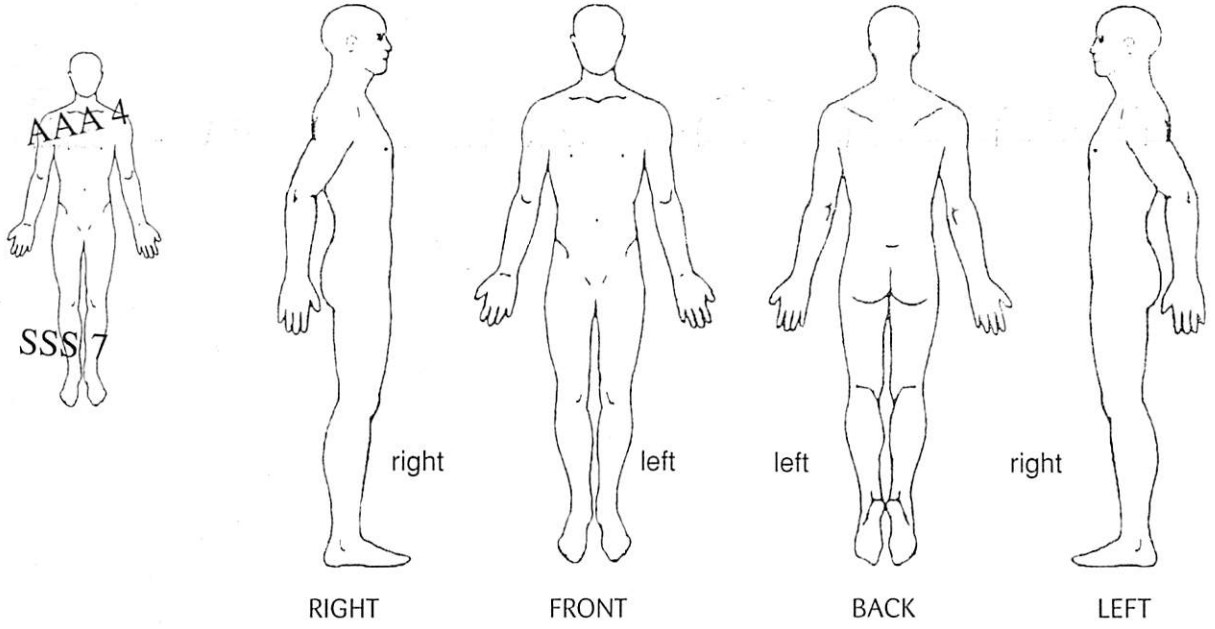
_____

SIGNATURE _____ DATE _____

Show us where it hurts

PLEASE MARK **AREA(S)** OF INJURY OR DISCOMFORT AS SHOWN IN THE EXAMPLE BELOW. MARK ALL AREAS WITH THE APPROPRIATE SYMBOLS AND INDICATE THE DEGREE OF PAIN USING A SCALE: FROM 1 (DISCOMFORT) TO 10 (EXTREME PAIN).

DESCRIPTION	NUMBNESS	PINS & NEEDLES	BURNING	ACHING	STABBING
SYMBOL	NNN	PPPP	BBBB	AAAA	SSSS



Doctors Notes

_____

_____

_____

_____

_____

_____

_____

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET

Automobile Accident Description

Please answer the questions below. If you do not know the answer to any of the questions, do not answer that question.

1. Your vehicle type

☐ Car ☐ Station Wagon
☐ Van ☐ Pickup Truck
☐ Large Truck ☐ Bus
Other_____

2. Your position in vehicle

☐ Driver ☐ Front Passenger
☐ Left Rear Passenger
☐ Right Rear Passenger
Other_____

3. What was your vehicle doing at the time of the accident?

☐ Stopped at intersection ☐ Stopped in traffic ☐ Stopped at light
☐ Making a right turn ☐ Making a left turn ☐ Parking
☐ Proceeding along ☐ Slowing down ☐ Accelerating
Other_____

4. Time/Speed/Damage

Time of accident_____
Your vehicle's speed: _____mph
Their vehicle's speed: _____mph
Damage to your vehicle
☐ Mild ☐ Moderate
☐ Totaled

5. Details of Accident

Visibility at time of accident
☐ Poor ☐ Fair ☐ Good

Who hit who/what?
☐ You hit other vehicle
☐ Other vehicle hit you
You hit...(object)
_____

6. Road conditions

Road conditions at time of accident
☐ Icy ☐ Wet ☐ Sandy ☐ Dark ☐ Clean and dry

Point of impact
☐ Head-On ☐ Left Front ☐ Right Front
☐ Read-End ☐ Left Rear ☐ Right Rear

7. Body Position, etc.

Did you see the accident coming: **Yes☐☐ No**
Were you braced for the impact? **Yes☐☐ No**
Did you have a seat belt on? **Yes☐☐ No**
Did you have a shoulder harness on? **Yes☐☐ No**

Does your vehicle have headrests? Yes☐☐ No
What was the position of your headrest at the time of the impact?
☐ Even with top of head ☐ Even with bottom of head ☐ Middle of neck
What was the direction of your head at the time of the impact?
☐ Facing straight forward ☐ Turned to the right ☐ Turned to the left

Did driver side air bags deploy? **Yes☐☐ No** Did passenger side airbags deploy? **Yes☐☐ No** Did side airbags deploy? **Yes☐☐ No**

8. Additional accident information

In the case of a motor vehicle accident, enter any additional information here that is not covered by the above check offs.

9. During the accident:

Did your body strike the inside of your vehicle? **Yes☐☐ No**
If yes, describe:_____
Did you lose consciousness during the injury? **Yes☐☐ No**
If yes, for how long? _____
Your vehicle's estimated damage? _____
Damage to their vehicle: ☐ Mild ☐ Moderate ☐ Totaled
Did police show up at the scene? **Yes☐☐ No**
Was an accident report filled out? **Yes☐☐ No**

10. After the accident:

Check off your symptoms right after and a few days following:
☐ Headache ☐ Dizziness ☐ Mid back pain ☐ Cold hands
☐ Neck pain ☐ Nausea ☐ Low back pain ☐ Cold feet
☐ Neck stiffnes ☐ Confusion ☐ Nervousness ☐ Diarrhea
☐ Fainting ☐ Fatigue ☐ Loss of taste ☐ Depression
☐ Ringing in ears ☐ Tension ☐ Toe numbness ☐ Anxious
☐ Loss of smell ☐ Irritability ☐ Constipation ☐ Chest Pain
☐ Pain behind eyes ☐ Shortness of breath ☐ Sleeping problems
Others:_____

11. Emergency Room?

Where did you go after the accident?
☐ Home ☐ Work ☐ Hospital ER ☐ Private Doctor
How did you get there?
☐ Drove self ☐ Somebody else ☐ Ambulance ☐ Police
Were X-rays done? Yes☐☐ No **Was lab work done?** Yes☐☐ No
Body parts X-rayed?_____
What lab work?_____
The X-rays revealed:_____
Treatments: ☐ Cervical Collar ☐ Ice **Other:**_____
Medications:_____
Follow-up instructions:_____
_____

12. Treatment History:

Fill in any other doctor(s) seen prior to your first visit to this office.
1. Dr. _____ First visit date: ___/___/___
Specialty:_____ X-rays done? **Yes☐☐ No**
Types of treatments received:_____
How many treatments received? ____ Currently treating? **Yes☐☐ No**
Did treatments benefit you? **Yes☐☐ No**
Last visit date: ___/___/___
2. Dr. _____ First visit date: ___/___/___
Types of treatments received:_____
How many treatments received? ____ Currently treating: **Yes☐☐ No**
Did treatments benefit you? **Yes☐☐ No**
Last visit date: ___/___/___

Activities of Daily Living Assessment

Rate your current difficulties, resulting from your accident/illness, with regard to the various activities listed below. Use the following 1 to 5 scale and **WRITE IN THE APPROPRIATE NUMBER** that most closely describes your current degree of difficulty: **1** = "I can do it without any difficulty" **2** = "I can do it without much difficulty, despite some pain", **3** = "I manage to do it by myself, despite marked pain", **4** = "I manage to do it, despite the pain, but only if I have help", **5** = "I cannot do it at all, because of the pain". **NOTE: Only fill in areas that are affected.**

Difficulties with Self Care and Personal Hygiene Activities

Bathing ..... ___	Drying hair ..... ___	Brushing teeth ..... ___	Putting on shoes ..... ___	Preparing meals ..... ___	Taking out trash.. ___
Showering ..... ___	Combing hair ..... ___	Making bed ..... ___	Tying shoes ..... ___	Eating ..... ___	Doing laundry ..... ___
Washing hair .. ___	Washing face ..... ___	Putting on shirt .... ___	Putting on pants ..... ___	Cleaning dishes ..... ___	Going to toilet ..... ___

Difficulties with Physical Activities

Standing ..... ___	Walking ..... ___	Kneeling ..... ___	Bending back ..... ___	Twisting left ..... ___	Leaning back..... ___
Sitting ..... ___	Stooping ..... ___	Reaching ..... ___	Bending left ..... ___	Twisting right ..... ___	Leaning left ..... ___
Reclining ..... ___	Squatting ..... ___	Bending forward .. ___	Bending right ..... ___	Leaning forward ..... ___	Leaning right ..... ___
Standing for long periods ..... ___		Sitting for long periods..... ___		Walking for long periods..... ___	Kneeling for long periods ..... ___

Difficulties with Functional Activities

Carrying small objects ..... ___	Lifting weights off floor ..... ___	Pushing things while seated .... ___	Exercising upper body ..... ___
Carrying large objects ..... ___	Lifting weights off table ..... ___	Pushing things while standing .. ___	Exercising lower body ..... ___
Carrying brief case ..... ___	Climbing stairs ..... ___	Pulling things while seated ..... ___	Exercising arms ..... ___
Carrying large purse ..... ___	Climbing inclines ..... ___	Pulling things while standing .... ___	Exercising legs ..... ___

Difficulties with Social and Recreational Activities

Bowling ..... ___	Jogging ..... ___	Swimming ..... ___	Ice Skating ..... ___	Competitive Sports . ___	Dating ..... ___
Golfing ..... ___	Dancing ..... ___	Skiing ..... ___	Roller Skating ..... ___	Hobbies ..... ___	Dining out ..... ___

Difficulties with Travelling

Driving a motor vehicle ..... ___	Riding as a passenger in a motor vehicle ..... ___	Riding as a passenger on a train ..... ___
Driving for long periods of time ..... ___	Riding as a passenger on an airplane ..... ___	Riding as a passenger for long periods ..... ___

Use the following **1 to 5** scale to describe the difficulties below:
1 = "This area is not affected by my condition", **2** = "This area is slightly affected by my condition", **3** = "My condition moderately restricts my ability in this area", **4** = " My condition seriously limits my ability in this area", **5** = "My condition prevents me from using this ability"

Difficulties with Different Forms of Communication

Concentrating....____ Hearing....____ Listening....____ Speaking....____ Reading....____ Writing....____ Using a keyboard....____

Difficulties with the Senses

Seeing.....____ Hearing.....____ Sense of touch.....____ Sense of taste.....____ Sense of smell.....____

Difficulties with Hand Functions

Grasping.....____ Holding.....____ Pinching.....____ Percussive movements.....____ Sensory discrimination.....____

Difficulties with Sleep and Sexual Function

Being able to have normal, restful nights sleep.....____ Being able to participate in desired sexual activity.....____

Write in below any additional information regarding your Activities of Daily Living (that wasn't covered above):

Prior Symptom History

Prior Similar Symptoms

- ☐ I have NOT had prior symptoms similar to my current complaints.
- ☐ My current complaints DID exist before, but have not been bothering me.
- ☐ My current complaints ALREADY existed and were worsened.

Has your History Contributed to your Current Symptoms?

- ☐ My history HAS contributed to my current symptoms.
- ☐ My history HAS NOT contributed to my current symptoms.
- ☐ I'm NOT SURE if my history has contributed to my current symptoms.

My most recent prior similar symptoms (**if applicable**) occured.....____ ☐ months ago / ☐ years ago **Or on** Date: ____/____/____

Write in below any other Prior Symptom History, not covered above:

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR

ACCIDENT, PRIVATE AND GROUP HEALTH INSURANCE

I hereby direct and instruct the _____ Insurance Company to pay by check made out and mailed directly to:

INJURY RELIEF CHIROPRACTIC

IF MY CURRENT POLICY PROHIBITS DIRECT PAYMENT TO THE DOCTOR, THEN I HEEREBY ALSO DIRECT AND INSTRUCT YOU TO MAKE OUT THE CHECK TO ME AND MAIL IT AS FOLLOWS:

INJURY RELIEF CHIROPRACTC

The professional or medical expense benefits allowable and otherwise payable to me under my current policy as payment towards the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentiones assignee, and I have agreed to pay, in current manner, any balance of said professional service charges over and above the insurance payment.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

I also authoorize the release of any information pertinent to my case to any insurance company, adjustor, or attorney invoved in this case.

DATED AT Injury Relief Chiropractic THIS _____ DAY OF _____

_____ _____

SIGNATURE OF POLICYHOLDER WITNESS

_____

SIGNATURE OF CLAIMANT, IF OTHER THEN POLICYHOLDER

AUTO ACCIDENT/PERSONAL INJURY FINANCIAL AGREEMENT

IT IS THE POLICY OF THIS OFFICE TO HAVE THE PATIENT OR THE PATIENT'S ATTORNEY PROVIDE US WITH THE NECESSARY INFORMATION.

IN THE EVENT THAT THE AUTO INSURANCE/ ATTORNEY DENIES PAYMENT FOR SERVICES RENDERED TO YOU BY THIS CLINIC, THAT UNPAID PORTION WILL BE TRANSFERRED TO YOU.

THE FOLLOWING CRITERIA MUST BE MET IN ORDER FOR A PORTION OF THE DOCTOR'S FEE TO BE DEFERRED UNTIL A SETTLEMENT HAS BEEN REACHED:

1. ALL AUTO ACCIDENT CASES INVOLVING NO FAULT CLAIMS MUST PROVIDE A COPY OF THEIR AUTO INSURANCE CARD AND ALSO HAVE AN "APPLICATION OF BENEFITS" FORM SIGNED.

2. IN ALL CASES, IF AN ATTORNEY IS INVOLVED, A DOCTOR'S LIEN FORM MUST BE SIGNED BY THE PATIENT AND THE REPRESENTING ATTORNEY. THIS ALLOWS THE REMAINING DOCTOR'S FEE TO BE PAID FROM THE FINAL SETTLEMENT.

3. THE MERITS OF YOUR CASE MUST BE ESTABLISHED BY YOUR ATTORNEY AND COMMUNICATED TO THE DOCTOR(S)

IN CONSIDERATION OF YOUR UNDERTAKING CARE OF ME, I AGREE TO THE FOLLOWING:

IN THE EVENT ANY INSURANCE COMPANY/ ATTORNEY OBLIGATED BY CONTRACTUAL AGREEMENT TO MAKE PAYMENT TO ME OR TO THE CLINIC FOR CHARGES MADE FOR YOUR SERVICES REFUSES TO MAKE SUCH PAYMENT WITHIN 60 DAYS OF YOUR BILLING, I WILL BE RESPONSIBLE FOR THAT AMOUNT, I WILL HAVE 30 DAYS TO CLEAR THAT ACCOUNT BY CALLING MY INSURANCE COMPANY/ ATTORNEY AFTER BEING NOTIFIED BY YOUR OFFICE. IN ANY EVENT, IF MY BALANCE IS NOT CLEARED IN FULL WITH YOUR OFFICE AND SERVICES OF AN OUTSIDE COLLECTION AGENCY IS REQUIRED; I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ANY AND ALL ADDITONAL COLLECTION COSTS IN ADDITON TO MY OUTSTANDING BALANCE INCLUDING BUT NOT LIMITED TO ATTORNEY'S FEE, COURT COSTS, ETC.

I ALSO UNDERSTAND THAT IF I SUSPEND OR TERMINATE MY CARE AND TREATMENT, ANY FEES FOR PROFESSIONAL SERVICES RENDERED ME WILL BE IMMEDIATELY DUE AND PAYABLE.

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICY.

DATE SIGNATURE OF RESPONSIBLE PARTY

DATE WITNESS

Injury Relief Chiropractic

(678) 710-3073 Fax (678) 501-5174*

ASSIGNMENT, LIEN AND AUTHORIZATION

INSURANCE BENEFITS AND ATTORNEY

I hereby authorize and direct you, my insurance company, and/or my attorney, to pay directly to Injury Relief Chiropractic, LLC. (hereinafter called "IRC") such sums as may be due nd owing Injury Relief Chiropractic for services rendered me, both by reason of accident or illness, and by reason of any other bills that are due IRC and to withold such from any disability benefits, medical payments beneifts, Medical insurance benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgement, or verdict on my behalf as may be necessary to adequately protect IRC. I hereby further give a lein to IRC against any and all insurance benefits named herein, any and all proceeds of any settlement, judgement, or verdict which may be paid to me as result of the injuries or illness for which I have been treated by IRC. This is to act as as an assignment of my rights and benefits to the extent of "IRC" services provided.

In the event my insurance company, obligated to make payments to me upon the charges made by IRC for their services, refuse to make such payments, upon demand by me or IRC, I hereby assign and transfer to IRC any and all causes of action that I might have or might exist in my favor against such company and authorize IRC to prosecute said cause of action either in my name or IRC name and further I authorize IRC to compromise, settle or otherwise resolve said claim or cause of action as they see fit. I authorize IRC to release any information, pertinent to my case to any insurnce company adjustor, or attorney to facilitate collection under this Assignment, Lien and Authorization. I agree that IRC be given Power of Attorney to endorse/sign my name on any and all checks for payment of my my doctor bill. I authorize my attorney to give a copy of any settlemnt statement, check/draft or Release to IRC.

Sworn to and subscribed before me **Patient's Signature:**

This_____day of _____. _____

The undersigned, being the attorny of record for the above named patient, by such sign signture below acknowledges receiing a copy of this instructment

Attorney's Signature:

_____

HEALTH CARE AUTHORIZATION FORM

Name _____

SS#_____ Date of Birth_____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES DR. EVELYN FLEMONS, INJURY RELIEF CHIROPRACTIC TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING

SPECIFIC AUTHORIZATION (please circle all that apply)

- I give permission to Injury Relief Chiropractic, to use my address, phone number, andclinical records to contact me with appointment notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information. I also give permission allowing my name to be posted on a referral board or my picture to be posted on message board for office related events. In the future should I write a testimonial regarding my treatment in this office, I give permission for it to be posted.
- If Injury Relief Chiropractic contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail, or with the individual who answers the telephone.
- I give Injury Relief Chiropractic permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.
- By signing this form, you are giving Inuury Relief Chiropractic, permission to use and disclose your protected health information in accordance with the directives listed above.

RIGHT TO REVOKE AUTHORIZTION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Injury Relief Chiropractic. The wriiten notice must contain the following information:

Your social security number and date of birth, a clear statement of your intent to revoke this AUTHORIZATION, the date of your request, and your signature.

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by Injury Relief Chiropractic, for its own use/disclosure of Protected Health Information. (Minimum standards apply.)

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, Injury Relief Chiropractic, will not refuse to provide treatment.

You have the right to inspect or copy the PHI to be used/disclosed.

** ** A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU** **

Print name of Patient _____

Signature _____

Date _____

Signature of Personal Representative_____