

# CHIROPRACTIC AND WELLNESS

DR. MARC J. BROWNER

3200 Bailey Lane #225 \* Naples, Florida 34105

## CONFIDENTIAL PATIENT ENTRANCE INFORMATION

PLEASE PRINT

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_

SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Sex: M F Marital Status: M S D W

Occupation: \_\_\_\_\_ Employed By: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Work Address: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

Appt reminders through text messaging? yes  no

List your chief complaints in order of severity and for how long you have been experiencing them:

1. \_\_\_\_\_ For how long? \_\_\_\_\_
2. \_\_\_\_\_ For how long? \_\_\_\_\_
3. \_\_\_\_\_ For how long? \_\_\_\_\_
4. \_\_\_\_\_ For how long? \_\_\_\_\_

Have you ever been to a Chiropractor before? Yes No If yes, when? \_\_\_\_\_

List doctors consulted for these conditions:

1. \_\_\_\_\_ Address/Phone: \_\_\_\_\_
2. \_\_\_\_\_ Address/Phone: \_\_\_\_\_

### If this is an injury:

1. Work-related? Yes No If yes, have you reported it to your employer?

2. Related to a motor vehicle crash? Yes No

If this is due to a crash, fill out the appropriate report forms which will be provided to you.

1. ALL FIRST VISIT CHARGES ARE PAYABLE WHEN SERVICES RENDERED.

NAME OF PARENT OR FINANCIALLY RESPONSIBLE PERSON: \_\_\_\_\_

2. THE FEE PAID FOR CHIROPRACTIC X-RAYS IS FOR STRUCTURAL ANALYSIS ONLY.

3. METHOD OF PAYMENT YOU PLAN TO TAKE CARE OF TODAY'S CHARGES

Cash\_\_\_\_ Check\_\_\_\_ Visa/MC\_\_\_\_

4. Do you have any type of insurance? Yes No

FEMALES: Are you pregnant? Yes No Not Sure

## HEALTH HISTORY

Are you taking any of the following medications?

Nerve Pills    Pain Killers (including aspirin)    Muscle Relaxers    Stimulants    Blood Thinners    Insulin    Other(s) \_\_\_\_\_

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

<input type="checkbox"/> Heart Attack/Stroke	<input type="checkbox"/> Heart Surgery/Pacemaker	<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Congenital Heart Defect	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Artificial Valves
<input type="checkbox"/> Alcohol/Drug Abuse	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> HIV/Aids	<input type="checkbox"/> Shingles	<input type="checkbox"/> Cancer
<input type="checkbox"/> Frequent Neck Pain	<input type="checkbox"/> Emphysema/Glaucoma	<input type="checkbox"/> Anemia
<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Psychiatric Problems	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Severe/Frequent Headaches	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Ulcers/Colitis
<input type="checkbox"/> Fainting/Seizures/Epilepsy	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Asthma
<input type="checkbox"/> Diabetes/Tuberculosis	<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Chemotherapy
<input type="checkbox"/> Lower Back Problems	<input type="checkbox"/> Artificial Bones/Joints	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Digestive Problems	<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Nose Bleeds

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?   Y   N   Exercise?   Y   N   If yes, describe: \_\_\_\_\_

Do you smoke?   Y   N   If yes, how much? \_\_\_\_\_ How long? \_\_\_\_\_

Are you wearing:    Heel lifts    Sole lifts    Inner Soles    Arch Supports    Orthotics

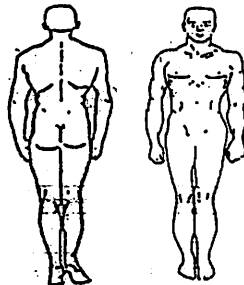
Current Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Women: Are you taking Birth Control?   Y   N   Are you pregnant?   Y   N   If yes, how far along? \_\_\_\_\_ Are you nursing?   Y   N

All Patients: Please Mark Problem Area(s):

Is the Pain:

Sharp/Stabbing    Aching  
 Pins & Needles    Burning



I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature \_\_\_\_\_ Date \_\_\_\_\_

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**AUTO RELATED CRASH**

Date & Time of Crash: \_\_\_\_\_

Were you the:  Driver  Front Passenger  
 Rear Passenger

If a traffic violation was issued, to whom was it issued?  
\_\_\_\_\_

Number of people in crash vehicle? \_\_\_\_\_

Did the police come to the crash site?  Yes  No

Was a police report filed?  Yes  No

Were there any witnesses?  Yes  No

Were you wearing your seat-belt?  Yes  No

Was the vehicle equipped with airbags?  Yes  No

If yes, did it/they inflate?  Yes  No

What did your vehicle impact?  Another vehicle  Other

If other, explain: \_\_\_\_\_

Did any part of your body strike anything in the vehicle?

Yes  No If yes, describe: \_\_\_\_\_

Make & Model of vehicle you were occupying?  
\_\_\_\_\_

Location/Street of crash site? \_\_\_\_\_

In which direction were you headed?  N  S  E  W

What was the approximate speed of your vehicle? \_\_\_\_\_

Did the impact to your vehicle come from the:

Front  Rear  Right Side  Left Side

During impact, were you facing:  Right  Left  Forward

Were you:  Aware OR  Surprised by the impact?

If crash vehicle made impact with another vehicle, what was the Make and Model of other vehicle:  
\_\_\_\_\_

Direction other vehicle was headed?  N  S  E  W

Speed of other vehicle? \_\_\_\_\_

In your words, please describe the crash:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**AFTER INJURY**

Did the accident render you unconscious?  Yes  No

If yes, for how long? \_\_\_\_\_

Please describe how you felt immediately after the crash?  
\_\_\_\_\_  
\_\_\_\_\_

Did your symptoms begin:  Immediately  
 Later that day  Other If other, when?  
\_\_\_\_\_  
\_\_\_\_\_

Have you gone to a Hospital or seen any other Doctor due to this crash?  Yes  No

When did you go?  Immediately  Next Day  2 days plus

Did you go by:  Ambulance OR  Private Transportation

Name of Hospital and/or Attending doctor:  
\_\_\_\_\_  
\_\_\_\_\_

Was he/she a:  D.C.  M.D.  D.O.  D.D.S.  Other

Describe treatment received: \_\_\_\_\_  
\_\_\_\_\_

Were X-ray's taken?  Yes  No

Was medication prescribed?  Yes  No

Have you been able to work since this injury?  Yes  No

Are your work activities restricted?  Yes  No

Indicate symptoms that are a result of this accident?

Dizziness  Jaw Problems

Memory Loss  Arm/Shoulder Pain

Headache(s)  Numb Hands/Fingers

Blurred Vision  Chest Pain

Buzzing in Ear  Shortness of Breath

Ears Ringing  Upset Stomach

Difficulty Sleeping  Nausea

Irritability  Back Pain

Fatigue  Low Back Pain

Tension  Back Stiffness

Neck Pain  Leg Pain

Neck Stiffness  Numb Feet/Toes

Other: \_\_\_\_\_

Is your condition getting worse?  Yes  No

Is the pain:  Constant OR  Comes & Goes

**Indicate your degree of comfort while performing the following activities:**

	Comfortable	Uncomfortable	Painful
Lying on Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on Stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stretching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____			

Have you retained an attorney:  Yes  No

If yes, whom: \_\_\_\_\_

Phone #: \_\_\_\_\_

## Insurance Information

Please provide a copy of your insurance card, driver's license and any secondary insurance information to our front desk.

Insurance Company: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Policy No.: \_\_\_\_\_ Claim #: \_\_\_\_\_  
Insured's Name: \_\_\_\_\_ Sex: M F  
Insured's Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship to Insured: \_\_\_\_\_  
Do you have health insurance? Yes No

### **FOR BLUE CROSS/BLUE SHIELD AND UNITED HEALTH CARE PATIENTS:**

As a courtesy to you, we will file your claims on your behalf. Please be advised that all insurance monies will be **paid directly to you/the insured. You will be responsible for forwarding the checks to our office.** Furthermore, you will allow IChiropractic and Wellness to call BCBS to verify insurance payment and allow BCBS to disclose the amount of payment for services rendered.

**Patient Acknowledgment:** I have been given a copy of IChiropractic and Wellness's Notice of Privacy Practice, version effective April 14, 2003. By signing this form, I give my consent to this office's use and disclosure of protected health information about myself for treatment, payment and health care operations, as well as those purposes set forth in the Notice of Privacy.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance in my account for any professional services rendered.

Furthermore, I understand that IChiropractic and Wellness will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to IChiropractic and Wellness will be credited to my account upon receipt.

However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

I also understand that if I suspend or terminate my care, any fees for professional services rendered me will be immediately due and payable.

I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my health insurance status or the above information.

### **RELEASE & ASSIGNMENT**

I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physician.

**Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_  
**Print Name:** \_\_\_\_\_  
**Spouse's Name or Guardian Signature:** \_\_\_\_\_

**IN ORDER TO DETERMINE WHICH INSURANCE IS RESPONSIBLE PLEASE FILL OUT  
THE FOLLOWING FORM:**

**STOP AFTER YOU ANSWER YES TO ANY QUESTION.**

**DO YOU HAVE AUTO INSURANCE AND IS IT YOUR POLICY?**

**DO YOU AUTO INSURANCE AND ARE YOU A LISTED DRIVER ON THE POLICY? IF  
SO, WHAT IS THE POLICY HOLDERS NAME AND D/O/B. DO YOU LIVE IN THE  
SAME HOME?**

**DO YOU OWN AN AUTOMOBILE?**

**DO YOU LIVE WITH A FAMILY MEMBER THAT HAS AUTO INSURANCE?**

**WERE YOU IN SOMEONE ELSE'S CAR WHEN DURING THE ACCIDENT AND THAT  
PERSON HAS INSURANCE ON THE VEHICLE?**

**CHIROPRACTIC AND WELLNESS  
MARC J. BROWNER, D.C.  
3200 BAILEY LANE STE. 225 NAPLES, FL 34105  
239-300-1756**

**ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND**  
***Insurer and Patient Please Read the Following in its Entirety Carefully!***

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile Insurance, a/k/a Personal Injury Protection (hereinafter PIP), Uninsured Motorist, and Medical Payments policy of insurance to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered. I understand this document will allow the provider to file suit against an insurer for payment of the insurance benefits or an explanation of benefits and to seek \$627,428 damages from the insurer. If the provider's bills are applied to a deductible, I agree this will serve as a benefit to me. This assignment of benefits includes the cost of transportation, medications, supplies, over due interest and any potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider the maximum amount directly without any reductions & without including the patient's name on the check. The patient agrees, before the services are provided, that the amount the provider charges for services are reasonable, usual and customary. This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original.

**Disputes:** The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider (specifically the office manager) and the insurer as to the amount payable under the insurance policy. The insured and the provider hereby contests and objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted. If the PIP insurer states it can pay claims at 200% of Medicare then the insurer is instructed & directed to provide this provider with a copy of the policy of insurance within 10 days. **Any effort by the insurer to pay a disputed debt as full satisfaction must be mailed to the address above, after speaking with the office manager, and mailed to the specific attention of the Office Manager. See Fla. Stat. §673.3111.**

To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance is declared voided, rescinded, or canceled, I, as the named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to file suit for recovery of the premiums. The insurer is directed to issue such a refund check payable to this provider only. Should the medical bills not exceed the premium refunded, then the provider is directed to mail the patient/named insured a check which represents the difference between the medical bills and the premiums paid.

**EUOs and IMEs:** If the insurer schedules a defense physical examination (hereinafter an IME) or examination under oath (hereinafter "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose. The provider is authorized and entitled to copy of the IME report and the EUO.

**Payment agreement:** I agree to pay: for all services; any applicable deductible or co-payment; for services rendered after the policy of insurance exhausts; and for any other services unrelated to the automobile accident in a timely fashion.

**Express Consent and Release of information:** For the next seven years, I authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other medical providers, the patient's attorney and hired experts via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information (declaration sheet & policy of insurance) in writing and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer; obtain copies of the entire claim file, the property damage file, and all medical records, including but not limited to, documents, reports, scans, notes, bills, opinions, X-rays, IMEs, and MRIs, from any other medical provider or any insurer.

For the next seven years, the provider is permitted to produce my medical records to its attorney and experts in connection with any pending lawsuits. The patient's other medical providers are authorized to sign affidavits and testify justifying the patient's care and treatment. The insurer is directed to keep the patient's medical records from this provider private and confidential. The insurer is not authorized to provide the patient's medical records to anyone without the patient's and the provider's prior express written permission.

The health care provider is given the power of attorney to endorse my name on any check for services rendered by the above provider and to request a copy of any medical records, statements or examinations under oath given by the patient.

**Demand:** Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else is received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is received by the insurer on the same day then the insurer is directed to pay this provider first before the policy is exhausted. In the event the provider's medical bills are disputed or reduced by the insurer for any reason, or amount, the insurer is to: set aside the entire amount disputed or reduced; escrow the full amount at issue; and not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a Court. Do not exhaust the policy. The insurer is instructed to inform, in writing, the provider of any dispute and when the policy is exhausted.

**Certification:** I certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; and I agree the provider's prices for medical services, treatment and supplies are reasonable, usual and customary.

**Caution: Please read before signing. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.**

Patient's Name \_\_\_\_\_

Patient's Signature \_\_\_\_\_  
(If patient is a minor, signature of parent/guardian)

Date \_\_\_\_\_



**ICHIROPRACTIC AND WELLNESS**  
3200 Bailey Lane #225  
Naples, FL 34105  
239-300-1756  
239-000-0000 fax

**RECORDS RELEASE REQUEST**

I, \_\_\_\_\_ give permission for the release of my records from  
\_\_\_\_\_. I hereby request that all written  
reports and records pertaining to the automobile accident of \_\_\_\_\_ be  
faxed to IChiropractic and Wellness at 239-596-4204.

These records can also be emailed to [DrBrowner@ICHIROPRACTIC.net](mailto:DrBrowner@ICHIROPRACTIC.net)

**Patient Info**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

SS# \_\_\_\_\_

Date of Service: \_\_\_\_\_

\_\_\_\_\_  
**Patient or Legal Signature**

\_\_\_\_\_  
**Witness**

Date: \_\_\_\_\_

# **ICHIROPRACTIC AND WELLNESS**

## **NOTICE OF PRIVACY PRACTICES – SHORT FORM**

Our practice is committed to educating our patients about healthcare issues that affect them. As a result, we are providing you with general information about the Privacy Rule, a federal regulation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) along with a brief overview of our Notice Of Privacy. Our practice is complying with HIPAA's regulations.

**What is the HIPAA and how does the Privacy Rule affect you?**

When the Health Insurance Portability and Accountability Act (HIPAA) was passed in August of 1996 this gave the federal government the ability to mandate how healthcare plans, providers, and clearinghouses store and send a patient's personal information as it relates to healthcare. The Privacy Rule was created to protect your rights as a patient of our practice and we are required by law to be compliant with this regulation on April 14, 2003. Under the Privacy Rule you are guaranteed access to your medical records, allowed control over how your protected health information is used and disclosed and allowed to take action if your privacy is compromised by following the practice's policy. Our practice is dedicated to maintaining the privacy of your personal information.

**What is Individually Identifiable Health Information (IIHI)?**

Any health information you provide our practice, including your mailing address. Information that is created and retained by our practice or received by another healthcare provider that relates to treatment, payment and/or that identifies you as an individual.

**What is the Notice of Privacy Practice?**

Our practice has an official Notice of Privacy Practice posted in our waiting room informing our patients about their rights surrounding the protection of your IIHI and our obligations concerning the use and disclosure of your IIHI. This notice applies to all records created or retained by our practice. We can update our Notice of Privacy Practices at any time. It will be posted in our office and you can ask for a copy of the current notice at any time.

The following categories describe the different ways in which we may use and disclose your IIHI:

Treatment	Appointment Reminders	Release of Information to Family/Friends
Payment	Treatment Options	Disclosure Required by Law
Health Care Operations	Health-Related Benefits and Services	

The following categories describe unique situations in which we may use or disclose your identifiable health information:

Public Health Risk	Health Oversight Activities	Lawsuits and Similar Proceedings
Deceased Patients	Organ and Tissue Donation	Serious Threats to Health or Safety
Military	National Security Inmates	Worker's Compensation
Law Enforcement	Research	

**What are your rights concerning your individually Identifiable Health Information (IIHI)?**

You have rights regarding the IIHI that we maintain about you. In our Notice of Privacy you can view the policies and procedures you will need to follow for the areas listed below.

1. Confidential Communications
2. Requesting Restrictions
3. Inspection and Copies
4. Amendment
5. Accounting of Disclosures
6. Right to a Paper Copy of This Notice
7. Right to File a Complaint
8. Right to Provide an Authorization for Other Uses and Disclosures

If you have any questions regarding this notice or our health information privacy policies, please inform us.

Signature \_\_\_\_\_ Date \_\_\_\_\_

# **ICHIROPRACTIC AND WELLNESS**

**3200 Bailey Lane #225**

**Naples, FL 34105**

## **CHIROPRACTIC INFORMED CONSENT TO TREAT**

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 on the patient named below, for whom I am legally responsible) by the doctor of the 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 serving as 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, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office of clinic personnel the nature and purpose of chiropractic adjustments and 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, dislocations 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 judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

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.

---

Patient Signature

Date

