



Please fill out this form as completely as possible. It will help us make our first session more productive, and may help you clarify what your goals for chiropractic care are. If you are unsure about any of the questions, please feel free to discuss this. (You can fill this out on your computer, if you like, and then print it. **Please do not email the forms, for privacy reasons.**)

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Let's Find Out Why You're Here...

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And How You Got to Where You Are Now...

Have you ever:

If yes, briefly explain

-broken a bone? Yes No

-been hospitalized? Yes No

-been struck unconscious? Yes No

-been in an auto accident? Yes No

Have you had any **surgery**? (Please list ALL surgeries) Yes No

Type: _____ Approximate Date: _____

Type: _____ Approximate Date: _____

Please list any **conditions** you have been diagnosed with (e.g. heart disease, cancer, diabetes, etc.):

Please list any **medications** (prescription and/or over-the-counter) that you are currently taking and what they are for:

Please list any **supplements, herbal, homeopathic, and/or natural remedies** you are currently taking:

Please list any specific health problems from your **family's history** that you believe are significant to you

OFFICE & FINANCIAL POLICIES

1. Fees are due and payable at the time services are rendered.

We accept cash, checks, and major credit cards.

2. Missed appointments and appointments cancelled without 24 hours' notice will be charged \$25. These fees will be billed to you or collected on your next visit.

3. Checks returned for any reason will incur a \$30 fee.

4. This office **does not bill insurance but will provide you a superbill should you wish to bill your own insurance. Please be aware that insurance companies DO NOT cover homeopathic treatment or the cost of remedies.**

5. Healthcare Savings Accounts and Flexible Spending Account dollars may be used to pay for services.

6. Homeopathic Product Information: All sales on homeopathic products are FINAL. Returns will NOT be accepted.

7. Please refrain from using strong fragrances (perfumes, lotions, oils, etc.) before your appointment. Some practice members are sensitive to such smells.

I understand the OFFICE & FINANCIAL POLICIES outlined above and agree to abide by them.

(signature)

(date)

DISCLOSURE AND INFORMED CONSENT FOR TREATMENT:

I understand that I will be receiving treatment from a licensed Doctor of Chiropractic. Treatment may include chiropractic adjustments, physiological interventions (such as homeopathic remedies), and case specific interventions. The adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. A vertebral subluxation is a misalignment or distortion of your spinal column or related structures that can affect your brain, nervous system and overall body function. Subluxations can cause pain, dis-ease and/or loss of proper body function.

I understand that homeopathy is a complementary form of healing and is not a replacement for standard medical care. This form of treatment is not intended to supplant or replace treatment given by other licensed practitioners. Dr. Keppy will prescribe remedies for your self care to be self administered, as needed.

I understand that, due to the nature of disease, individual motivation for compliance with the doctor's recommendations, and because people are biologically and genetically unique, that no claims or guarantees are or can be made as to the outcome of this form of treatment. No cure, improvement, or outcome is or can be guaranteed for any condition. Compliance with any recommendations are undertaken by, and the responsibility of myself as client or parent/guardian of the client.

We do not offer to medically diagnose or treat any disease, symptom or condition. No matter what condition(s) you may have been diagnosed with and no matter what symptom(s) your body is expressing, you always need a body free from subluxations. If, during the course of our chiropractic examination, we encounter unusual findings that are out of the scope of chiropractic practice, we will let you know of them. You may then decide whether you wish to investigate further and discuss your healthcare options with other healthcare professionals. We will cooperate with you and with them regarding your healthcare goals.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

(signature)

(date)

Privacy Policy

Health Insurance Portability and Accountability Act (HIPAA)

Consent for Purpose of Treatment, Payment and Healthcare Operations

Q&A: We are committed to protecting your privacy. This policy describes how we collect, use, and disclose your information. We will only use your information for the purposes stated in this policy. You have the right to access, correct, or delete your information. If you have any questions, please contact us at [phone number].

Q&A: We are committed to protecting your privacy. This policy describes how we collect, use, and disclose your information. We will only use your information for the purposes stated in this policy. You have the right to access, correct, or delete your information. If you have any questions, please contact us at [phone number].

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T&A: We are committed to protecting your privacy. This policy describes how we collect, use, and disclose your information. We will only use your information for the purposes stated in this policy. You have the right to access, correct, or delete your information. If you have any questions, please contact us at [phone number].

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S&A: We are committed to protecting your privacy. This policy describes how we collect, use, and disclose your information. We will only use your information for the purposes stated in this policy. You have the right to access, correct, or delete your information. If you have any questions, please contact us at [phone number].

Patient Signature

Date

Please Print Patient Name