Notice of 24 hour Cancellation:

We are now implementing a 24 hour cancellation policy in order to accommodate all of our patients. With the exception of emergencies, you will be charged with an office visit equal to the charge of the visit scheduled. This policy gives time and opportunity for patients waiting on a list to be seen, and gives consideration to our therapists' time. Moving forward, we will require a Credit Card to be kept on file in our records to enforce this policy and ensure our providers are compensated for their time and lost revenue.

Thank you for your consideration of others!

____(sign) _____________________________(date)

Date:__________________

Name: ____ Home Phone: _____________________
Address: ____City:___________________ State: ________ Zip: ________
E-mail Address: ____ Cell Phone: _______________________
Age: ___________ Birth Date: ________________ Gender: M F
Occupation: ______________________________ Employer: ____________________________________
Emergency Contact: _____________________________
Address: _______________________________________Phone:________________________
Family Medical Doctor:
____
How did you hear about us?

Medical Information:

Are you taking any medications? Yes no

If yes, please list: ____

Are you currently pregnant? Yes no If yes, how far along? _____________________________

Any high risk factors_____________________________

Do you suffer from chronic pain? Yes No

If yes, please explain: ____

What makes it better? _____________________________ What makes it worse? _____________________________

Please indicate any of the following that apply to you:

Cancer	Fibromyalgia
Headaches/Migraines	Stroke
Arthritis	Heart Attack
Diabetes	Kidney Dysfunction
Joint Replacement(s)	Blood Clots
High/Low Blood Pressure	Numbness
Neuropathy	Sprains or Strains

Please Explain any conditions marked above:____

Client Signature: ____ Date: ___/___/___

Massage Informed Consent

By signing below, you agree to the following:

1) I give my permission to receive massage therapy.

2) I understand that therapeutic massage is not a substitute for traditional medical treatment or medications.

3) I understand that the massage therapist does not diagnose illnesses or injuries, or prescribe medications.

4) I have clearance from my physician to receive massage therapy.

5) I understand the risks associated with massage therapy include, but are not limited to:

• Superficial bruising

• Short-term muscle soreness

• Exacerbation of undiscovered injury

I therefore release Align Sports Chiropractic and Health Center and the individual massage therapist from all liability concerning these injuries that may occur during the massage session.

6) I understand the importance of informing my massage therapist of all medical conditions and medications I am taking, and to let the massage therapist know about any changes to these. I understand that there may be additional risks based on my physical condition.

7) I understand that it is my responsibility to inform my massage therapist of any discomfort I may feel during the massage session so he/she may adjust accordingly.

8) I understand that I or the massage therapist may terminate the session at any time.

9) I have been given a chance to ask questions about the massage therapy session and my questions have been answered.

Client Signature: ____ Date: ___/___/___

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

As part of my health care, Align Sports Chiropractic, creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results and plans for future care.

I understand that this information serves as a basis for my continuing care.

I understand that this information is used as a means of communication among Align Sports Chiropractic personnel and with medical personnel outside of this practice.

I understand that this information serves as a source of information for applying my diagnoses and surgical information to my bill.

I understand that this information is a way for third party insurance companies to assure that a service we bill for was actually performed.

I understand that this information can be used as a tool to assess the quality of care provided to patients.

I have been provided an opportunity to review the Notice of Privacy Practices for the Align Sports Chiropractic that provides a more complete review of information used and disclosures.

I understand that I have the right to review this Notice of Privacy Practice before signing this consent.

I understand that the Align Sports Chiropractic may change its Notice of Privacy Practices at any time and that a current copy will be available for my inspection during regular business hours of each medical office and at t he central billing office.

I understand that I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment or other healthcare operations and that the Align Sports Chiropractic is not required to agree to the restrictions requested. The procedures to request restriction on information used and disclosure is contained in the Notice of Privacy Practices.

I Acknowledge that I have received a copy of the Notice of Privacy Practices of Align Sports Chiropractic and agree to the liability limitations explained therein.

______________________________ ______________ ________________

Signature of Patient or Legal Representative. Date Relationship to Patient

____

Printed Name of Patient

Effective Date April 14, 2003

Align SPORTS CHIROPRACTIC & HEALTH CENTER

For TODAY's visit:

- Do you prefer :

  Light pressure   Medium pressure   Deep pressure

- Do you prefer to hold a conversation during your session with your massage therapist?

  Yes

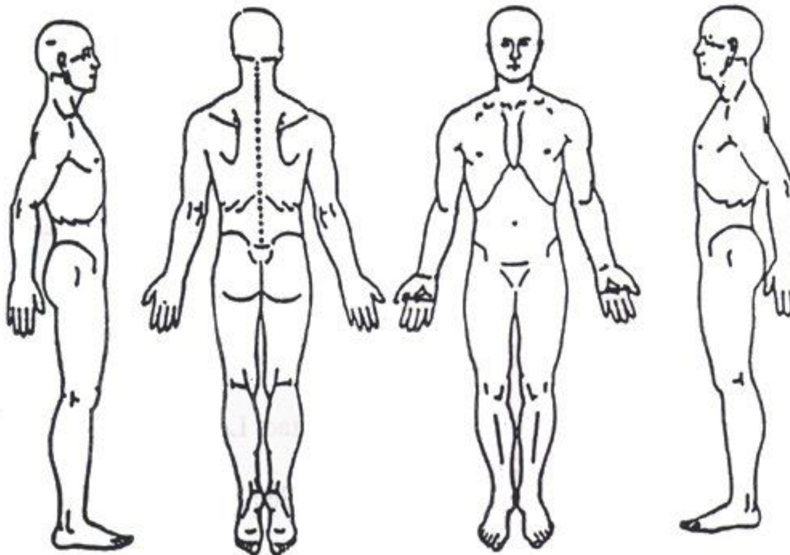
  No

- Any areas you would prefer your massage therapist avoids?

  No

  Yes. Please explain: ____

- Where would you like your massage therapist to concentrate?



Client Signature: ____Date:___/___/____