MILLVILLE CHIROPRACTIC CENTER

1014 NORTH HIGH STREET
MILLVILLE, NJ 08332

PIP Patient Packet

Please READ and complete pages 1 thru 12

Please READ and sign pages 8, 9, 10, 11, and 12

Important Notice to all new Millville Chiropractic Center personal injury patients.

Below is a list of important documentation that we require you to bring on your first appointment to help us better serve you.

1. Photo ID
2. Auto Insurance Card
3. Health Insurance Card
4. Declaration page to your auto policy
5. Police report (usually takes 7-10 business days)
6. Claim number
7. New patient personal injury packet (pick up at office at least 24 hrs in advance to your appointment or print from our website @ www.millvillechiropracticcenter.com)

If you do not have these items readily available on your first visit, we may need to reschedule your appointment.

We are here to help you have the best chiropractic experience, if you have any questions regarding the above listed documents, feel free to contact our office at (856) 327-0320.

Your appointment is:

on_____@_____with_____

Millville Chiropractic Center

1014 N High St, Millville, NJ 08332

PERSONAL INFORMATION

Today's Date: _____

Name: _____ **S.S. #:** _____

Marital Status: □ S □M □ W □D **Date of Birth:** _____

Age: _____ □ Male □Female **Address:** _____

_____

City State Zip code

How many Children: ___

Occupation: _____ □ Full Time □ Part Time

Employer: _____ **Home Tel #** _____

Name of Spouse: _____ **Cell #** _____

Spouse's Date of Birth: _____ **Work #** _____

Spouse's Occupation: _____ **Spouse's Cell #** _____

Emergency Contact: _____ **Emergency Phone #:** _____

Patient E-Mail Address: _____

INSURANCE INFORMATION

Please Provide A Picture ID, Your Auto, and Health Insurance Card

Auto Insurance Company: _____ **Attorney's Name:** _____

Date of Accident: _____ **State Accident Occurred:** _____

Have you notified your Auto Insurance Carrier: □Yes □No

If yes, were you assigned a Claim Number: □Yes □No

If yes, Claim Number: _____

If Name Is Different From the Policy Holder **(Policy Holder Is: Parent or Spouse)**

Policy Holder's Name: _____ **S.S. #:** _____

Policy Holder's Date of Birth: _____ **Age:** _____ □Male □Female

Health Insurance Company: _____

Policy Number: _____ **Group #** _____

If Name Is Different From the Policy Holder **(Policy Holder Is: Parent or Spouse)**

Policy Holder's Name: _____ **S.S. #:** _____

Policy Holder's Date of Birth: _____ **Age:** _____ □Male □Female

Were you referred to this office? □Yes □No

If yes, who do we need to thank? _____

If no, how did you find our office? _____

In Order For This Office, its Physicians, and it's Agents to BETTER HELP YOU Please READ and COMPLETE the Following Questions.

If This Is NOT A MOTOR VEHICLE ACCIDENT, Please SKIP DOWN TO PAGE 3

AUTO ACCIDENT INFORMATION

Date of Accident/Injury: _____ **Time of Day:** _____ ☐**AM** ☐**PM**

I was: ☐**Driver** **I was:** ☐**Passenger**
☐**Front Seat** ☐**Middle** ☐**Right**
☐**Rear Seat** ☐**Left** ☐**Middle** ☐**Right**

IF OTHER THAN YOURSELF, DRIVER WAS: _____

What type of vehicle were you in? _____

What type was the other vehicle? _____

I was stopped at: ☐**Stop Sign** ☐**Traffic Signal** ☐**Due to traffic** ☐**Other** _____

I was traveling: ☐**Forward** ☐**Turning Right** ☐**Turning Left**
☐**Backing up** ☐**Turning Right** ☐**Turning Left**

I was struck on:				
	☐**Front**	☐**Left**	☐**Center**	☐**Right**
	☐**Driver side**	☐**Front**	☐**Center**	☐**Rear**
	☐**Passenger Side**	☐**Front**	☐**Center**	☐**Rear**
	☐**Rear**	☐**Left**	☐**Center**	☐**Right**

I struck other vehicle on:				
	☐**Front**	☐**Left**	☐**Center**	☐**Right**
	☐**Driver side**	☐**Front**	☐**Center**	☐**Rear**
	☐**Passenger Side**	☐**Front**	☐**Center**	☐**Rear**
	☐**Rear**	☐**Left**	☐**Center**	☐**Right**

Impact caused my vehicle to: ☐**Hit another vehicle** ☐**Hit a Pole** ☐**Hit a Wall** ☐**Hit a Fence**
☐**Spin out of control** ☐**Flip over** ☐**Other** _____

Wearing seatbelt: ☐**Yes** ☐**No**
Air Bag deployed: ☐**Yes** ☐**No**
If child, restrained: ☐**Car Seat** ☐**Booster Seat** ☐**Other** _____

I struck my	**... against:**				
☐**Head**	☐**Windshield**	☐**Steering**	☐**Dashboard**	☐**Headrest**	☐**Door**
☐**Face**	☐**Windshield**	☐**Steering**	☐**Dashboard**	☐**Headrest**	☐**Door**
☐**Chest**	☐**Windshield**	☐**Steering**	☐**Dashboard**	☐**Headrest**	☐**Door**
☐**Rt. Shoulder**	☐**Windshield**	☐**Steering**	☐**Dashboard**	☐**Headrest**	☐**Door**
☐**Lt. Shoulder**	☐**Windshield**	☐**Steering**	☐**Dashboard**	☐**Headrest**	☐**Door**
☐**Rt. Leg**	☐**Windshield**	☐**Steering**	☐**Dashboard**	☐**Headrest**	☐**Door**
☐**Lt. Leg**	☐**Windshield**	☐**Steering**	☐**Dashboard**	☐**Headrest**	☐**Door**
☐**Rt. Knee**	☐**Windshield**	☐**Steering**	☐**Dashboard**	☐**Headrest**	☐**Door**
☐**Lt. Knee**	☐**Windshield**	☐**Steering**	☐**Dashboard**	☐**Headrest**	☐**Door**
Other:					

IF ACCIDENT/INJURIES WERE DUE TO A MOTOR VEHICLE ACCIDENT PLEASE CONTINUE TO "AT THE TIME OF ACCIDENT"

IF ACCIDENT/INJURIES WERE NOT DUE TO A MOTOR VEHICLE ACCIDENT, PLEASE WRITE IN YOUR OWN WORDS HOW ACCIDENT/INJURY HAPPENED

_____

_____

_____

_____

_____

_____

_____

AT THE TIME OF THE ACCIDENT/INJURY

I had loss of consciousness: ☐**Yes** ☐**No**
I was dazed: ☐**Yes** ☐**No**
I complained of: _____

_____

I had bruises to: _____

_____

I had cuts to: _____

_____

Police Responded to scene of accident: ☐**Yes** ☐**No**

Paramedics/Fire Rescue Responded to ☐**Yes** ☐**No**

If yes, what did Paramedics/Fire Rescue perform:

☐**Nothing** ☐**Cut me out of the vehicle** ☐ **IV was started**
☐**Head/neck immobilized** ☐**Placed on long spine board** ☐ **Oxygen given**
☐**Transported to hospital by:** ☐**Ambulance** ☐**Air Rescue**

Name of hospital you were transported to by Paramedics: _____

At the hospital I had:

☐**X-Rays** ☐**CT scan** ☐**MRI** ☐**Stitches** ☐**Cast to my** _____
☐**Prescription medication** ☐**Referred to Specialist** ☐**Emergency Surgery**
☐**Hospitalized for:** _____**day(s)** ☐**Other** _____

☐**I did not seek medical attention at the time of the accident**

☐**I continued about my day** ☐**I went to work** ☐**I went home**

I followed up with family doctor: **Name:** _____ **Date:** _____

Treatment: _____

☐**I followed up with Orthopedic:** **Name:** _____ **Date:** _____

Treatment: _____

☐**I followed up with Neurologist:** **Name:** _____ **Date:** _____

Treatment: _____

☐**I followed up with other:** **Name:** _____ **Date:** _____

Treatment: _____

☐**I later went to hospital/clinic:** **Name:** _____ **Date:** _____

At the hospital/clinic I had:

☐**X-Rays** ☐**CT scan** ☐**MRI** ☐**Stitches** ☐**Cast to my** _____

☐**Prescription medication** ☐**Referred to Specialist** ☐**Emergency Surgery**

☐**Hospitalized for:** _____**day(s)** ☐**Other** _____

Since the accident what have you been doing for your symptoms:

☐**Nothing** ☐**Over the counter medications** ☐**RX/prescription medication**

☐**Hot/cold packs** ☐**Massages** ☐ **Other**_____

Please List Each of Your Complaints SEPARATELY And in ORDER of PRIORITY:

1) Chief Complaint: _____

What do you believe may be the cause of your complaint? _____

How long have you had this condition? _____

What makes your condition feel worse? _____

What makes it feel better? _____

The pain is: ☐ **Constant** ☐ **Comes and goes** ☐ **Other** _____

The pain is worse in the: ☐ **Morning** ☐ **Afternoon** ☐ **Evening** ☐ **Other** _____

How much pain, on a scale of 0 to 10 (0 is no pain and 10 is the worst pain ever) are you having? _____

What kind of pain are you having? (Sharp, dull, etc…) _____

Is the pain radiating? ☐**Yes** ☐**No** **If yes where does the pain radiate into?** _____

2) Additional complaint: _____

What do you believe may be the cause of your complaint? _____

How long have you had this condition? _____

What makes your condition feel worse? _____

What makes it feel better? _____

The pain is: ☐ **Constant** ☐ **Comes and goes** ☐ **Other** _____

The pain is worse in the: ☐ **Morning** ☐ **Afternoon** ☐ **Evening** ☐ **Other** _____

How much pain, on a scale of 0 to 10 (0 is no pain and 10 is the worst pain ever) are you having? _____

What kind of pain are you having? (Sharp, dull, etc…) _____

Is the pain radiating? ☐**Yes** ☐**No** **If yes where does the pain radiate into?** _____

3) Additional complaint: _____

What do you believe may be the cause of your complaint? _____

How long have you had this condition? _____

What makes your condition feel worse? _____

What makes it feel better? _____

The pain is: ☐ **Constant** ☐ **Comes and goes** ☐ **Other** _____

The pain is worse in the: ☐ **Morning** ☐ **Afternoon** ☐ **Evening** ☐ **Other** _____

How much pain, on a scale of 0 to 10 (0 is no pain and 10 is the worst pain ever) are you having? _____

What kind of pain are you having? (Sharp, dull, etc…) _____

Is the pain radiating? ☐**Yes** ☐**No** **If yes where does the pain radiate into?** _____

Since accident/injury I am unable to:

☐**Stand more than** _____ **minutes** ☐**Sit more than** _____ **minutes**
☐**Walk more than** _____ **minutes** ☐**Run more than** _____ **minutes**
☐**Lift more than** _____ **pounds** ☐**Other:** _____

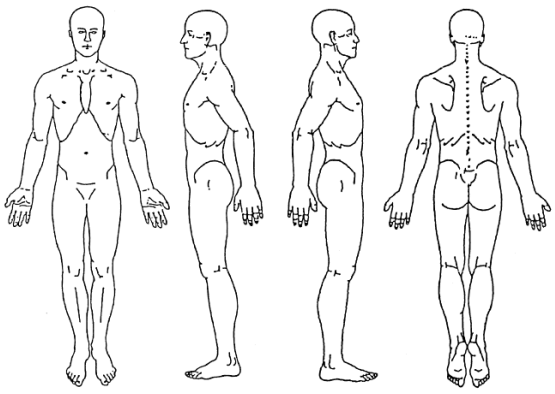
Pain Scale: On a scale of 0 ï 10, rate your pain: (Please circle the number that best describes your pain)

No Pain **Severe Pain**

0 1 2 3 4 5 6 7 8 9 10

Please use the legend symbols below to accurately mark the areas in which you feel these sensations:

Stabbing/Cutting - ////
Tingling - ****
Burning - XXXX
Cramping - ^^^^
Numbness - NNNN
Dull - ####



Describe the overall severity of the pain:

☐**Mild Nuisance** ☐**Mild to moderate, but can live with it**
☐**Moderate, having trouble coping with it** ☐ **Severe, it is ruining my quality of life**

Is there any other information that you believe may be important to the doctor to know?

_____

_____

_____

_____

Have you returned to work since accident/injury: ☐Yes ☐No

PAST MEDICAL HISTORY

Previous Accidents/Injuries	Date	Resolved
1		☐Yes ☐No
2		☐Yes ☐No
3		☐Yes ☐No

Hospitalizations for	Date	Resolved
1		☐Yes ☐No
2		☐Yes ☐No
3		☐Yes ☐No

Surgeries Performed	Date	Resolved
1		☐Yes ☐No
2		☐Yes ☐No
3		☐Yes ☐No
4 PACEMAKER?		☐Yes ☐No

I also have a past medical history of:

☐TMJ	☐Vertigo	☐Allergies	☐Memory Loss	☐High Blood Pressure
☐Fractures	☐Anemia	☐Migraine	☐Loss of Vision	☐Diabetes
☐Headaches	☐Epilepsy	☐Digestive	☐Eating Disorder	☐Heart/Cardiac
☐Sinus	☐Hearing	☐Fractures	☐Kidney Problems	☐Cholesterol
☐Liver	☐Prostate	☐Gallbladder	☐Ringing of the ears	☐Lung/Pulmonary
☐Ulcers	☐Arthritis	☐Hyperactive	☐Learning Disability	☐Stroke/CVA or TIA
			☐Depression/Anxiety	☐Cancer

☐Other: _____

BEFORE THIS ACCIDENT/INJURY I HAD COMPLAINTS OF:

□Headaches	□Jaw pain	□Stomach Pain	□Hip Pain	□Ringing of the ears
□Neck Pain	□Arm Pain	□Arm Numbness	□Hand Pain	□Hand Numbness
□Mid Back Pain	□Chest pain	□Rib Pain	□ Knee pain	□Shoulder Pain

□Other: _____

Have you been under Chiropractic care in the past? □Yes □No
If yes, Doctor's Name: _____ Date last seen: _____

Presently under care by your private medical physician for the above medical history: □Yes □No

If yes, Doctor's Name: _____ Date Last Seen: _____

Presently on RX/prescription medications for the above medical history: □Yes □No

Have you notified your private medical physician for your recent symptoms/injury: □Yes □No

ALLERGIES TO MEDICATIONS: □Yes □No

If yes, please list all: _____

_____

PERSCRIPTION MEDICATIONS: □Yes □No

If yes, please list all: _____

_____

OVER THE COUNTER MEDICATIONS: □Yes □No

If yes, please list all: _____

_____

VITAMINS/HERBS/SUPPLEMENTS: □ Yes □ No

If yes, please list all: _____

_____

FEMALES ONLY

First day of your last menstrual period: _____
Month / Day / Year

Are you pregnant? □Yes □No

If yes, when is your due date: _____
Month / Day / Year

Millville Chiropractic Center
1014 N High St, Millville, NJ 08332

FAMILY/SOCIAL HISTORY

Mother's History: □**Alive** □**Deceased**
□**High Blood Pressure** □**Diabetes** □**Heart Problems**
□**Lung Problems** □**Cancer** □**Osteoporosis/Osteoporoses**
□**CVA/Strokes** □**Other** _____

Father's History: □**Alive** □**Deceased**
□**High Blood Pressure** □**Diabetes** □**Heart Problems**
□**Lung Problems** □**Cancer** □**Osteoporosis/Osteoporoses**
□**CVA/Strokes** □**Other** _____

Do you drink alcohol: □**Yes** □**No**
If yes how often: _____

Do you use tobacco: □**Yes** □**No**
If yes how often: _____

Do you use recreational drugs: □**Yes** □**No**
If yes how often: _____

Do you workout/exercise: □**Yes** □**No**
If yes, prior to this accident/injury I worked out _____ per week
□**Walking _____ miles** □**Running _____ miles**
□**Bicycle _____ miles** □**Cardio Training**
□**Weight Training** □**Other:** _____

Patient Acknowledgement

By my signature, I understand and acknowledge that Millville Chiropractic Center its Physicians and agents will treat my condition, as they deem necessary through the use of Chiropractic Therapy and adjunctive therapies. I also understand that all original documents and original x-rays created as a result of the performance of examinations will remain the property of Millville Chiropractic Center. Millville Chiropractic Center it's Physicians and agents will not be held responsible for any undisclosed pre-existing conditions.

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify the doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Signature: _____ **Date:** _____

***PLEASE READ*: This questionnaire is designed to help this office to better understand how much your NECK pain has affected your ability to manage your everyday activities. Please answer each section by checking the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but PLEASE JUST CHECK THE ONE. CHOOSE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

Pain Intensity ☐ **I have no pain at the moment.** ☐ **The pain is very mild at the moment.** ☐ **The pain is moderate at the moment.** ☐ **The pain is fairly severe at the moment.** ☐ **The pain is very severe at the moment.** ☐ **The pain is the worst imaginable at the moment.**	**Concentration** ☐ **I can concentrate fully when I want to with no difficulty.** ☐ **I can concentrate fully when I want to with slight difficulty.** ☐ **I have a fair degree of difficulty in concentrating when I want to.** ☐ **I have a lot of difficulty in concentrating when I want to.** ☐ **I have a great deal of difficulty in concentrating when I want to.** ☐ **I cannot concentrate at all.**
Personal Care (Washing, Dressing, etc.) ☐ **I can look after myself normally without causing extra pain** ☐ **I can look after myself normally, but it causes extra pain** ☐ **It is painful to look after myself and I am slow and careful** ☐ **I need some help, but manage most of my personal care** ☐ **I need help every day in most aspects of self care** ☐ **I do not get dressed, I wash with difficulty and stay in bed**	**Work** ☐ **I can do as much work as I want to.** ☐ **I can only do my usual work, but no more.** ☐ **I can do most of my usual work, but no more.** ☐ **I cannot do my usual work.** ☐ **I can hardly do any work at all.** ☐ **I cannot do any work at all.**
Lifting ☐ **I can lift heavy weights without extra pain.** ☐ **I can lift heavy weights, but it gives extra pain.** ☐ **Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.** ☐ **Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.** ☐ **I can lift very lightweights.** ☐ **I cannot lift or carry anything at all.**	**Driving** ☐ **I can drive my car without any neck pain.** ☐ **I can drive my car as long as I want with slight pain in my neck.** ☐ **I can drive my car as long as I want with moderate pain in my neck** ☐ **I cannot drive my car as long as I want because of moderate pain in my neck.** ☐ **I can hardly drive at all because of severe pain in my neck.** ☐ **I cannot drive my car at all.**
Reading ☐ **I can read as much as I want to with no pain in my neck.** ☐ **I can read as much as I want to with slight pain in my neck.** ☐ **I can read as much as I want to with moderate pain in my neck.** ☐ **I cannot read as much as I want because of moderate pain in my neck.** ☐ **I cannot read as much as I want because of severe pain in my neck.** ☐ **I cannot read at all.**	**Sleeping** ☐ **I have no trouble sleeping.** ☐ **My sleep is slightly disturbed (less than 1 hour sleepless).** ☐ **My sleep is mildly disturbed (1-2 hours sleepless).** ☐ **My sleep is moderately disturbed (2-3 hours sleepless).** ☐ **My sleep is greatly disturbed (3-5 hours sleepless).** ☐ **My sleep is completely disturbed (5-7 hours)**
Headaches ☐ **I have no headaches at all.** ☐ **I have slight headaches, which come infrequently.** ☐ **I have moderate headaches, which come infrequently.** ☐ **I have moderate headaches, which come frequently.** ☐ **I have severe headaches, which come frequently.** ☐ **I have headaches almost all the time.**	**Recreation** ☐ **I am able to engage in all of my recreational activities with no neck pain at all.** ☐ **I am able to engage in all of my recreational activities with some pain in my neck.** ☐ **I am able to engage in most, but not all of my recreational activities because of pain in my neck.** ☐ **I am able to engage in a few of my recreational activities because of pain in my neck.** ☐ **I can hardly do any recreational activities because of pain in my neck.** ☐ **I cannot do any recreational activities at all.**

NAME: _____ **DATE:** _____

***PLEASE READ*: This questionnaire is designed to help us to understand how much your BACK pain has affected your ability to manage your everyday activities. Please answer each section by checking the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but PLEASE JUST CHECK THE ONE. CHOOSE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

Pain Intensity ☐**The pain comes and goes and is very mild.** ☐**The pain is mild and does not vary much.** ☐**The pain comes and goes and is moderate.** ☐**The pain is moderate and does not vary much.** ☐**The pain comes and goes and is severe.** ☐**The pain is severe and does not vary much.**	**Standing** ☐**I can stand as long as I want without pain.** ☐**I have some pain while standing, but it does not increase with time.** ☐**I cannot stand for longer than one hour without increasing pain.** ☐**I cannot stand for longer than ½ hour, without increasing pain.** ☐**I cannot stand for longer than ten minutes, without increasing pain.** ☐**I avoid standing, because it increases the pain straight away.**
Personal Care ☐**I would not have to change my way of washing or dressing in order to avoid pain.** ☐**I do not normally change my way of washing or dressing even though it causes some pain.** ☐**Washing and dressing increases the pain, but I manage not to change my way of doing it.** ☐**Washing and dressing increases the pain and I find it necessary to change my way of doing it.** ☐**Because of the pain, I am unable to do some washing and dressing without help.** ☐**Because of the pain, I am unable to do any washing or dressing without help.**	**Sleeping** ☐**I get no pain in bed.** ☐**I get pain in bed, but it doesn't prevent me from sleeping well** ☐**Because of my pain, my normal night's sleep is reduced by less than one-quarter.** ☐**Because of my pain, my normal night's sleep is reduced by less than one-half.** ☐**Because of my pain, my normal night's sleep is reduced by less than three-quarters.** ☐**Pain prevents me from sleeping at all.**
Lifting ☐**I can lift heavy weights without extra pain.** ☐**I can lift heavy weights, but it causes extra pain.** ☐**Pain prevents me from lifting heavy weights off the floor.** ☐**Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table** ☐**Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.** ☐**I can only lift very light weights, at the most.**	**Social Life** ☐**My social life is normal and gives me no pain.** ☐**My social life is normal, but increases the degree of my pain.** ☐**Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc.** ☐**Pain has restricted my social life and I do not go out very often.** ☐**Pain has restricted my social life to my home.** ☐**I have hardly any social life because of the pain.**
Walking ☐**Pain does not prevent me from walking any distance.** ☐**Pain prevents me from walking more than one mile.** ☐**Pain prevents me from walking more than ½ mile.** ☐**Pain prevents me from walking more than ¼ mile.** ☐**I can only walk while using a cane or on crutches.** ☐**I am in bed most of the time and have to crawl to the toilet.**	**Traveling** ☐**I get no pain, while traveling.** ☐**I get some pain while traveling, but none of my usual forms of travel make it any worse.** ☐**I get extra pain while traveling, but it does not compel me to seek alternate forms of travel.** ☐**I get extra pain while traveling which compels me to seek alternative forms of travel.** ☐**Pain restricts all forms of travel.** ☐**Pain prevents all forms of travel except that done lying down.**
Sitting ☐**I can sit in any chair as long as I like without pain.** ☐**I can only sit in my favorite chair as long as I like.** ☐**Pain prevents me from sitting more than one hour.** ☐**Pain prevents me from sitting more than ^{1}/a hour.** ☐**Pain prevents me from sitting more than ten minutes.** ☐**Pain prevents me from sitting at all.**	**Changing Degree of Pain** ☐**My pain is rapidly getting better.** ☐**My pain fluctuates, but overall is definitely getting better.** ☐**My pain seems to be getting better, but improvement is slow at present.** ☐**My pain is getting neither better nor worse.** ☐**My pain is gradually getting worse.** ☐**My pain is rapidly worsening**

NAME: _____ **DATE:** _____

ASSIGNMENT AND AUTHORIZATION OF INSURANCE BENEFITS

I have read and understand the following prior to signing. I hereby authorize Millville Chiropractic Center to furnish information concerning my condition and treatment to any insurance carrier. I further assign to Millville Chiropractic Center all payments any insurance carriers are obligated to make on my behalf for services rendered. I understand that payment for all medical services rendered is my responsibility and agree to pay monthly. I understand that my insurance may not cover all fees charged by Millville Chiropractic Center

I certify that I have been informed that my preliminary authorization/precertification for payment obtained by Millville Chiropractic Center's office is not a guarantee of payment as per my insurance company's guidleines.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this chiropractic office by an insurance company will be credited to my account on 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, _____, have read and fully understand the above information and agree to receive chiropractic care under these terms.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

COMPLETE IF PATIENT IS A MINOR CHILD _____ **(Child's Name)**

I, _____ being the parent or legal guardian of the above minor child have read and fully understand the above information and agree for my child to receive chiropractic care under these terms.

Signature: _____ Date: _____

Millville Chiropractic Center

1014 N High St., Millville, NJ 08332

Doctor-Patient Relationship in Chiropractic

It is important to be an aware and informed patient. We have found that an understanding of chiropractic care is helpful. This page is to help inform you of what will be happening today and throughout your care.

Analysis: You will receive a chiropractic examination for the detection of vertebral Subluxations. A vertebral Subluxations is a misalignment of one or more of the 24 vertebra in the spinal column that causes obstruction of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's natural ability to express its maximum health potential.

During the examination, the chiropractor will evaluate how your spine moves and what it feels like. Based upon the results of the examination, X-rays of your spine may be taken. X-rays will tell the doctor how far and in what direction the vertebra is misaligned. The X-rays will also help determine the most efficient chiropractic techniques to effectively adjust and correct the spine.

Diagnosis: Only a chiropractor can determine if your case is a chiropractic case. Your diagnosis will reflect spinal nerve interference that is caused by vertebral Subluxations. Our doctors will work with any other health care provider for your benefit. Also, you should expect other health care providers to work with your chiropractor for your benefit. This team approach to your health care will serve you the best.

Chiropractic Adjustments: By coming to the chiropractor for care, you give the chiropractor permission to adjust you. In rare cases, physical defects, deformities, or pathology may render the patient susceptible to injury. The chiropractor will not provide chiropractic adjustments if he is aware of any such conditions. If the patient is aware of any latent pathological defects, illness or deformities that would not otherwise come to the attention of the chiropractor, it is the patient's responsibility to notify the chiropractor. A chiropractor does not treat or diagnosis disease. The chiropractor provides a specialized health service for the detection and correction of vertebral Subluxations. Upon request, alternatives to chiropractic care and any risks regarding chiropractic care will be explained.

Results: The goal of chiropractic is to adjust vertebral Subluxations for the purpose of allowing the proper transmission of nerve energy over nerve pathways so that every part of the body may have a proper nerve supply at all times. This allows the natural healing ability of the body to work at maximum efficiency. Since there are many variables, it is difficult to predict the time schedule or results of chiropractic care. The healing process takes time. The longer the problem has been in the body, the longer the healing process will take.

Questions: We want to help you achieve your goal of health. Any time your progress is not satisfactory or you have any concerns, the chiropractor will gladly answer any questions that arise or assist you in choosing a referral doctor for another opinion. Your health is our number one priority.

Acknowledgment: I have read and understand the above.

Patient Name: _____ Signature: _____ Date: _____