Office Name: Express Life Chiropractic

Doctor(s) Name: Dr. Troy + Dr. Ashley Hayes

Practice Member Name: _____

Date of Accident: _____ Time of Accident: _____ City: _____ State: _____

Please contact YOUR car insurance company and obtain the following information.

Do you have Medical Pay on your Policy? YES NO

If Yes, coverage amount: $1,000 $2,000 $5,000 $10,000 $_____

Is your Medical Pay primary? YES NO

Personal Injury Claim #: _____

Personal Injury Adjuster's Name: _____

Adjusters Phone Number: _____ Extension _____

Insurance Company Name, Address & Fax Number:

_____

_____

_____

Fax Number: _____

Attorney Information

Have you retained an attorney? YES NO

Attorney Name: _____ Firm: _____

Phone Number: _____ Fax: _____

Other Driver (At Fault Driver) Insurance Information

Name: _____ Claim #: _____

At Fault Driver's Insurance Company Name & Address

_____

_____

_____

Personal Injury Adjuster's Name: _____

Adjusters Phone Number: _____ Extension _____

At Fault States: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Georgia, Idaho, Illinois, Indiana, Iowa, Louisiana, Maine, Maryland, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, Washington, West Virginia, Wisconsin & Wyoming

Express Life Chiropractic
8550 Andermatt Dr. Ste 2, Lincoln, NE 68526

Car Wreck Questionnaire

Patient Name _____ Date:_____

Date of Accident: _____

Your Position in Vehicle: Driver Passenger Seat Back Seat Other: _____

Vehicle Type (you were in) Year/Make/Model: _____

Speed of vehicle (you were in): _____

Speed of vehicle (Other vehicle/vehicles): _____

Collision Direction: Rear Ended T-Boned Hit in Side Driver/Passenger
Other: _____

Was there a second collision: Yes No If Yes, Explain:_____

Your Body Position at Collision (ie: Head Forward): _____

Did the airbags deploy: Yes No

Did your body make contact with the inside of the car: Yes No
If Yes, Explain:_____

Was your vehicle towed: Yes No

Did you go to the ER or an Urgent Care? Yes, where & how: _____
No

When is the first time you are seeking medical care? _____

Were you aware the accident was going to happen? _____

Express Life Chiropractic
Automobile/PI Accident or Work Comp Questionnaire

Patient's Name _____ **Date of Birth** _____ **Social Security Number** _____

Dear Patient:
This information is considered confidential. Your answers will help us determine if chiropractic care can help your condition. We will not accept your case if we do not believe your condition will respond satisfactorily to care. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form.
Thank you.

Please answer all questions completely.

Please explain in detail how your accident happened: _____

_____

_____

What were the time and date of present injury? _____

Where did you feel pain immediately after the accident? _____

List the extent of your injuries as you know them: _____

_____

_____

Did you require post-accident hospitalization? ☐ Yes ☐ No

Check symptoms you have noticed since the accident:

___ Headache
___ Light Bothers Eyes
___ Head Seems to Heavy
___ Pins and Needles in Arms
___ Sleeping Problems
___ Pins and Needles in Legs
___ Numbness in Fingers
___ Numbness in Toes
___ Shortness of Breath
___ Dizziness
___ Buzzing in Ears
___ Memory Loss
___ Ears Ring
___ Back Pain
___ Constipation
___ Loss of Smell
___ Loss of Taste
___ Stomach Upset
___ Depression
___ Diarrhea
___ Feet Cold
___ Hands Cold
___ Face Flushed
___ Tension
___ Fever
___ Chest Pain
___ Fatigue
___ Neck Pain
___ Neck Stiff
___ Fainting
___ Loss of Balance
___ Nervousness
___ Irritability
___ Cold Sweats

Symptoms other than above: _____

_____

Where were you taken after the accident? _____

Hospitalized? ☐ Yes ☐ No If yes, admitted? _____ How long? _____

Name of Hospital: _____

Name of Doctor(s): _____

Patient's Name _____ Date of Birth _____ HR#: _____

Was any other doctor consulted after your accident? ☐ Yes ☐ No

If so, what was the doctor's name? _____ D.C., M.D., D.O., D.D.S.

What was the diagnosis? _____

What treatment was given? _____

How often did you see the doctor? _____

How long did you see the doctor? _____

Have you ever had any complaints in the involved area before? ☐ Yes ☐ No

If so, what were the complaints? _____

Before the injury were you capable of working on an equal basis with others your age? ☐ Yes ☐ No

Are your work activities restricted as a result of this accident? ☐ Yes ☐ No

Since this injury are your symptoms ... ☐ Improving? ☐ Getting worse? ☐ Same?

Driver of other vehicle (if any):

Name _____ Insurance Company _____ Policy No. _____

Driver of vehicle in which you were injured (if applicable):

Name _____ Insurance Company _____ Policy No. _____

Name of your insurance adjustor _____

Have you retained an attorney? ☐ Yes ☐ No

If so, his/her name and address _____

You were heading North/ East/ South/ West on _____ (street or highway)

Other vehicle was heading North/ East/ South/ West on _____ (street or highway)

Were police notified? ☐ Yes ☐ No

Were you knocked unconscious? ☐ Yes ☐ No If yes, for how long? _____

You were struck from Behind/ Front/ Left Side/ Right Side _____

You were Driver/ Passenger/ Front seat/ Back Seat/ Using seat belts _____

Patient Signature _____ Date _____

Doctor Signature _____ Date _____

T 1 2 3

ACTIVITIES OF DAILY LIVING

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITY:	EFFECT:			
Carrying Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climbing Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Household Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lifting Children	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Concentration (Reading)	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

Signature: _____ Date____ /_____ /_____

T 1 2 3

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name_____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain _____ **worst possible**

pain 0 1 2 3 4 5 6 7 8 9 10

1 – What is your pain RIGHT NOW?

No pain _____ **worst possible**

pain 0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain _____ **worst possible**

pain 0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain _____ **worst possible**

pain 0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain _____ **worst possible**

pain 0 1 2 3 4 5 6 7 8 9 10

COMMENTS:_____

Express Life Chiropractic
8550 Andermatt Dr. Ste. 2
Lincoln, NE 68526-9781

Final Lien Amount: _____
Claim No. _____

NOTICE OF DOCTOR'S LIEN

I hereby authorize and instruct my attorney &/or insurance carrier, _____ _____ to pay **Express Life Chiropractic** directly for the full amount of services rendered by **Express Life Chiropractic** in relation to my personal injury treatment arising from my accident on or about _____ once a settlement or verdict is reached and those funds are made available or disbursed.

I understand that I am directly and fully responsible for all medical bills incurred at **Express Life Chiropractic** for services rendered to me with respect to any personal injury treatment. Further, I understand that I am responsible for the payment of all services rendered by **Express Life Chiropractic**, regardless of whether or not I receive any proceeds from any insurance company or third party, and that my obligation and liability to **Express Life Chiropractic** is in no way conditioned upon any settlement of verdict.

I agree to promptly notify **Express Life Chiropractic** of any changes in my representation or attorney for this accident.

By signing below, I acknowledge and agree to this lien in favor of **Express Life Chiropractic** the full amount owed for any and all services rendered to me by **Express Life Chiropractic.**

I acknowledge that **Express Life Chiropractic** is not required to permit me the option to postpone or make payments toward of services rendered, and that it is being done solely as a courtesy. As such, **Express Life Chiropractic** may, at any time, seek payment for any and all amounts owed by me while this lien is in force. Additionally, if my attorney fails to acknowledge this lien in favor of **Express Life Chiropractic**, the entire balance related to this personal injury treatment is my sole responsibility, and **Express Life Chiropractic** may demand payment immediately.

_____ Print Practice Members Name

_____ Practice Member Signature

_____ Date

Acknowledged by Attorney this _____*day of* _____*, 20*_____

_____
Attorney Signature

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE PERSONAL INJURY, WORK COMP, ERISA, AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

Provider Name: Dr. Troy Hayes D.C.
Clinic: Express Life Chiropractic
Address: 8550 Andermatt Dr. Ste 2 Lincoln, NE 68526

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, any and all medical benefits and/or any insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of all medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

_____

Patient Signature

_____

Date

Express Life
CHIROPRACTIC

Personal Injury (Car Accident) Card on File

I, _____, understand that not paying up front for a car accident/bodily injury/worker's comp case is a courtesy to me and I give Express Life Chiropractic permission to run my card on file in the event that the Auto Insurance third party payer discontinues the PI case during the open PI claim or I stop communication with Express Life Chiropractic and/or my adjuster for my claim. I understand I am personally responsible for all of the services already rendered including, but not limited to exams, xrays, adjustments etc. and any balance due will be determined once all explanation of benefits have been received or by thirty days after notice of discontinuation or last time communication. I understand that I am also responsible for charges if the third party decides that care is not related to the accident or not medically necessary.

*If card doesn't go through, Express Life Chiropractic will send my case to collections for services rendered.

Signature: _____

Date: _____

ELC Team Member_____

T 1 2 3

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physician's certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRATICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclosed to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

_____ _____

(Signature) **(Date)**

Personal Injury/Auto Accident/Workers Comp. Policies and Fee Schedule

- **Consultation**- includes practice member history. This service is complimentary
- **Assessment (new or established practice member)-** includes one or more of the following: thermography, orthopedic/neurological evaluation, range of motion, motion and/or static palpation, leg check $250-$320.
- **Chiropractic Adjustment-** The actual re-alignment of the vertebra done by hand and/or instrument. Often a sound will be heard, but if there is no auditory result, it does not mean that the adjustment has not taken place. $80-$120.
- **X-rays-** Specific x-ray views taken of your spine to determine a misalignment/subluxation of your vertebrae. These can also be used to indicate progress after period of care. $60 per view. Reproduction of X-rays are $15 per copy.
-

Release of Authorization/Assignment of Benefits

I authorize and request payment of insurance benefits directly to Troy Hayes, D.C. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance.

A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the practice member's insurance at the time of service. Your health/auto insurance company will only pay for services that it determines to be "reasonable and necessary." Every effort will be made by this office to have all services and procedures pre authorized by your health/auto insurance company. If your health insurance company determines that a particular service is not reasonable and necessary, or that a particular service is not covered under the plan, your insurer will deny payment for that service. If my health/auto insurance company denies payment (in whole or in part), I understand that I am personally and fully responsible for payment. I also understand that if my health/auto insurance company does make payment for services, I will be responsible for any co-payment, deductible, out of pocket, or coinsurance that applies.

I understand that I am financially responsible for charges not covered by this assignment.

Signature_____ **Date**_____

T 1 2 3

EXPRESS LIFE CHIROPRACTIC HEALTH PROFILE

Name_____Date____/____/____Age_____Male/Female

Address_____City_____State____Zip_____

Phone: Home_____Cell_____Date of Birth_____/_____/_____

Email Address_____

For confirming appts, would you prefer? TEXT (cell carrier:_____) or EMAIL

Occupation_____Employer's Name _____

Single / Married / Divorced / Widowed Spouse's Name_____

Number of Children_____Names, Ages & Gender_____

_____

Social Security Number_____

Who may we thank for referring you? _____

Terms of Acceptance

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.
C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day doctors of chiropractic in the United States alone.
D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health though chiropractic
G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

By my signature below, I have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

_____ _____

(Signature) (Date)

T 1 2 3

INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARY TO CHIROPRACTIC CARE INCLUDE: SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE OCCURRING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER TWO MILLION CERVICAL SPINE (NECK) ADJUSTMENTS MAY BE A VERTEBRAL INJURY THAT COULD LEAD TO A STROKE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NEEDED, OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

PRINT PRACTICE MEMBER'S NAME HERE

PRACTICE MEMBER'S SIGNATURE

DATE

IF PRACTICE MEMBER IS A MINOR/CHILD, PARENT OR GUARDIAN MUST SIGN BELOW.

SIGNATURE OF PRACTICE MEMBER OR GUARDIAN

DATE

RELATIONSHIP TO MINOR/CHILD

WITNESS SIGNATURE (OFFICE STAFF)

DATE

T 1 2 3

XRAY AUTHORIZATION

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS. WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES.

AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF YOUR X-RAYS IN OUR FILES. HOWEVER, THE REPRODUCTION OF X-RAYS THERE WILL BE $15 SURCHARGE FOR THE DUPLICATION OF X-RAYS.

PLEASE NOTE: IF CLINICALLY NECESSARY X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE VERTEBRAL SUBLUXATIONS. THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF EXPRESS LIFE CHIROPRACTIC DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVICE.

BY SIGNING BELOW, YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS.

PRINT YOUR NAME HERE _____ DATE _____

SIGNATURE _____ YOUR AGE _____

FEMALE PATIENTS ONLY: TO THE BEST OF MY KNOWLEDGE, **I BELIEVE I AM NOT PREGNANT** AT THE TIME X-RAYS ARE TAKEN AT EXPRESS LIFE CHIROPRACTIC.

SIGNATURE _____ DATE _____

- **DO NOT WRITE BELOW THIS LINE**

For Office Use Only:

Notes;

X-rays: _____ PDR Date: _____ CA Initials: _____

Express Life Chiropractic's Appointment and Discontinue Policy

In our office we reserve our time to serve you and your family. We understand that life happens, and appointments may need to be changed or canceled for **emergent** reasons. In this event we request that you give our office a call within a minimum of **1 hour** prior to your scheduled appointment.

2 "no call no shows" are granted to a practice member in the event of an emergency but there is no tolerance for chronic "no call no shows". Following your **3rd** "no call no show" our billing department will automatically apply a one time **$100 NCNS** to the credit/debit card on file **per family member** at the end of the business day. Following this fee, the practice member and associated family members calendars will be deleted from our schedule. If the practice member at this point wishes to continue with their care, we will be happy to rebuild your care visits, but remember you have already exhausted our cancellation policy and there will be no more tolerance for missed visits. If you wish to restart care the cancellation policy will reset and the **$100 fee be applied on the first no call no show** of your resigned care.

Be **consistent** with your care will get you the best results in our office!

I understand the above cancellation policy as well as penalty fees that could be applied to my credit/debit card.

In order to discontinue care, we require that you come into the office to go over your account with a team member. This should be scheduled 24 hours in advance to allow for ample time to audit your account. At that time, we will either schedule the refund (within 15 days) or take payment for any balance left of the account.

Printed Name: _____

Signed: _____ Date: _____