ACTION POTENTIAL Chiropractic
Wellness Care for Children and Adults

Welcome

Confidential Patient Identification (03/09)

1143 SR 532
P.O. Box 1527
Camano Is. WA
(360)629-2524

Personal Info

Full Name_____ I like to go by_____Today's Date ____/____/____

Date of Birth_____ Age ____ Sex ____ Height ____ Weight ____

Address_____
Street City State ZIP

Social Security No._____ E-Mail _____

Home Phone (___) _____ Cell Phone (____)_____Work Phone (____)_____

Employer Name_____ Insurance Company _____

Marital Status M S W D Sep. Spouse_____

Children & ages_____

Guarantor _____ Referred by _____

Emergency Contact_____ Relationship _____

Day Phone_____ Evening Phone _____

Terms of Acceptance

Since health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity, we recognize the importance of proper spinal function to wellness. We know that a vertebral subluxation to one or more of the 24 vertebrae in the spinal column causes alterations of nerve function and interference to the transmission of the mental impulse, resulting in a lessening of the body's innate ability to express its maximum health potential.

The principle goal of chiropractic is to correct the vertebral subluxation. A chiropractic adjustment is the specific application of forces by a chiropractor to facilitate the body's correction of the subluxation.

This office does not offer to diagnose or treat any disease or condition. Our purpose is to detect, analyze and correct the vertebral subluxation. If, during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, or if you need medical attention, we recommend that you seek the services of a health care provider who specializes in that area.

Release of Medical Information

In the event that Action Potential Chiropractic, Inc., PS agrees to accept assignment and/or submit insurance claims on my behalf, I authorize the release of chiropractic or other information necessary to process claims and collect payments.

Notice of Privacy Practices

I have been presented with a copy of Notice of Privacy Policies, detailing how my health information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice, and I request the following restrictions(s) concerning the use of my personal health information: _____

_____

Further, I permit a copy of this authorization to be used in place of the original.

I have read, understand and agree to the above Terms of Acceptance, Release of Medical Information and Notice of Privacy Practices (HIPPA). (A copy of the HIPPA policies is available upon request).

Patient Name (Printed):_____

Patient Signature:_____Date: _____

If Patient is a Minor

If patient (above) is a minor, as his/her parent, I hereby give my permission for my son/daughter to receive chiropractic care at Action Potential Chiropractic and also agree to the above Terms of Acceptance, Release of Medical Information, and Notice of Privacy Practices (HIPPA). I am the guarantor for the above-named patient.

Parent/Legal Guardian:_____ Date: _____