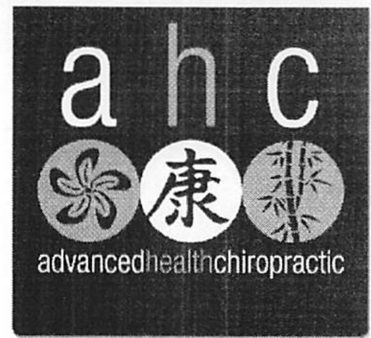


Patient Info Sheet

Last Name:_________________________ First_______________________

Address___________________________________ City__________ State_____ Zip_______________

Sex: M F DOB___________________ SS#___________________ DL#____________________

Home________________________ Cell________________________ Work___________________

How Do you Prefer we contact you? Home Cell Work Email

Email________________________________________________________________________________

Are you interested in text/email reminders?_______ If so mobile provider________________________

Employed by: ______________________________________________________________________

Emergency Contact_____________________ Relationship________________ Phone________________

Insureds Name_______________________________ Relationship to Insured______________________

Primary Insurance Name__________________ ID#____________________ Group#_______________

Secondary Insurance Name__________________ ID#___________________ Group#_______________

Are you here as a result of an auto accident or work injury?________

If yes, Claim #__________________ Date of Injury__________ Adjusters Name___________________

Phone________________________ Fax____________________ Company________________________

How did you find out about our office?_____________________________________________________

"Our purpose is to educate and adjust as many families as possible towards optimum health through natural chiropractic care."

**Advanced Health Chiropractic, L.L.C.**
**Melissa Perotti, D.C.**
**9570 S. McCarran Blvd. Ste. 110**
**Reno, NV 894523**
**(775) 746-2555**

# CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me ( or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase of any kind of symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains, and/or increased pain and inflammation. I do not expect or will not hold Melissa Perotti, D.C. at Advanced Health Chiropractic or any other treating physician assigned to my case by Dr. Perotti to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesic and rest: Medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had this read to me, the above consent. I have also had the opportunity to ask questions about it content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient: ______________________________________________

Signature of Patient: ___________________________________________

Printed Name of Parent/Guardian and Relationship to Patient: _______________________

Parent/Guardian Signature: ______________________________________

Date: ____________________

Doctor of Chiropractic Name: _____________________________________

Signature of Doctor of Chiropractic: _________________________________

Date: ______________________________

Witness: ____________________________________ Date: ____________________

# Authorization for release of
# Healthcare records

### Notice to Patient

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether the patient signs this form, unless permitted by law.

### Notice to Clinic

Always provide the patient with a copy of this signed form.

### Authorizing Signature

I authorize release of my healthcare records as stated herein. I understand that I have a right to inspect and receive a copy of the disclosed material. This authorization will remain in effect until the expiration date or this request is revoked through written notice submitted to the entity releasing the records.

Any revocation is not effective to the extent that the office/clinic had already released records in reliance on this form.

If this form is signed by a person other than the patient, their relationship to the patient and their authority to sign this authorization must be indicated below.

**Signature**______________________________________

**Date**__________________

**Relationship or authority**___________________________

**Office use Only;**

**Date received**______________

**Date processed**_____________

**Processed by**_________________

**Advanced Health Chiropractic**
**Melissa Perotti DC, CICE**
**9570 S. McCarran Blvd. Ste 110**
**Reno, NV 89523**
**Ph: (775) 746-2555**
**Fax: (775)746-2566**

**Insurance verification wavier:**

As a courtesy Advanced Health Chiropractic will do our best to verify your insurance coverage at the initial office visit or when a new insurance card is provided. It is your responsibility to provide the most up to date and accurate insurance information as possible. By verifying your coverage it does not guarantee payment or coverage. Though we will collect any copays, coinsurance amounts, or deductibles based on the insurance companies initial instruction in most cases the information will differ from how your insurance company actually processes the medical claim. It is your finical responsibility to pay for any balance due after your insurance processes.

Please sign and date below acknowledging that you understand that Advanced Health Chiropractic is not responsible for any lack of, difference in payment, or denial of coverage causing you the patient or the patient's guarantor to be responsible for the bill.

Name: ________________________________________________

DOB: ______________________ Phone: ______________________

Signature of Patient/ Guarantor: ______________________________

Print Name of Patient/ Guarantor: ____________________________