



Last Visit

Today's Date

Patient ID#

**Welcome to Our Office!**

Please fill out our Health Record as complete and accurate as possible. If you have any questions, please don't hesitate to ask. It is our pleasure to be of service to you. Our commitment to you is to promote the highest quality of health and well-being with chiropractic care.

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

E-Mail: \_\_\_\_\_ Birthday: \_\_\_\_\_

Gender: ☐ Male ☐ Female ☐ Other Marital Status: ☐ Married ☐ Single # of Children: \_\_\_\_

Employer: \_\_\_\_\_ Type of Work: \_\_\_\_\_

Who Referred you to this office? \_\_\_\_\_

**Emergency Contact**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Health Insurance**

Insurance Company: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group: \_\_\_\_\_

**About The Insured Person (If Not-Self)**

Insured's First Name: \_\_\_\_\_ Insured's Last Name: \_\_\_\_\_

Insured's Relation: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_

**Primary Complaint**

*(Please list one area for each complaint i.e. neck pain and headaches for primary complaint and low back pain for second complaint)*

Where is your primary problem located? \_\_\_\_\_

How did this problem begin? \_\_\_\_\_

When did this condition begin? \_\_\_\_\_

|   |   |  |
|---|---|--|
| Overall frequency of complaint<br>(please check only one)   | How intense is the pain/symptoms?   | How would you describe your problem?   |
| <input type="radio"/> Constant (100% of the time)<br><input type="radio"/> Frequent (51-75%)<br><input type="radio"/> Occasional (26-50%)<br><input type="radio"/> Intermittent (1-25%) | <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5<br><input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 10 | <input type="radio"/> aching <input type="radio"/> burning <input type="radio"/> dull<br><input type="radio"/> heavy <input type="radio"/> pulling/spasm <input type="radio"/> numb<br><input type="radio"/> sharp <input type="radio"/> stiffness <input type="radio"/> throbbing<br><input type="radio"/> tightness <input type="radio"/> tingling |

Does this problem travel to any other area of your body? If yes, please explain:

What makes the problem better? \_\_\_\_\_

What makes the problem worse? \_\_\_\_\_

Has this condition

☐ gotten worse   ☐ stayed the same   ☐ gotten better

Have you seen other doctors/medical providers  
for this condition?

☐ yes   ☐ no

Doctor/Provider's Name(s) \_\_\_\_\_

Type of Treatment: \_\_\_\_\_

Has any imaging or diagnostic testing been done?  
(i.e. X-Ray, MRI, EMG)

☐ yes   ☐ no

Has this condition occurred before?

☐ yes   ☐ no

### Secondary Complaint

Where is your primary problem located? \_\_\_\_\_

How did this problem begin? \_\_\_\_\_

When did this condition begin? \_\_\_\_\_

|   |   |  |
|---|---|--|
| Overall frequency of complaint<br>(please check only one)   | How intense is the pain/symptoms?   | How would you describe your problem?   |
| <input type="radio"/> Constant (100% of the time)<br><input type="radio"/> Frequent (51-75%)<br><input type="radio"/> Occasional (26-50%)<br><input type="radio"/> Intermittent (1-25%) | <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5<br><input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 10 | <input type="radio"/> aching <input type="radio"/> burning <input type="radio"/> dull<br><input type="radio"/> heavy <input type="radio"/> pulling/spasm <input type="radio"/> numb<br><input type="radio"/> sharp <input type="radio"/> stiffness <input type="radio"/> throbbing<br><input type="radio"/> tightness <input type="radio"/> tingling |

Does this problem travel to any other area of your body? If yes, please explain:

What makes the problem better? \_\_\_\_\_

What makes the problem worse? \_\_\_\_\_

Has this condition

☐ gotten worse   ☐ stayed the same   ☐ gotten better

Have you seen other doctors/medical providers  
for this condition?

☐ yes   ☐ no

Doctor/Provider's Name(s) \_\_\_\_\_

Type of Treatment: \_\_\_\_\_

Has any imaging or diagnostic testing been done?  
(i.e. X-Ray, MRI, EMG)  
☐ yes ☐ no

Has this condition occurred before?  
☐ yes ☐ no

### Medical History

Have you had any surgeries?  
☐ yes ☐ no

Please list surgeries and year:

Have you been hospitalized?  
☐ yes ☐ no

Please list when you were hospitalized and the reason:

Have you been in any previous  
Accidents or traumatic events?  
☐ yes ☐ no

Please list type of trauma and year:

Do you have a primary care provider?  
☐ yes ☐ no

Please list primary care provider and location:

Please list any prescribed medications:

Do you have any family history of cancer, diabetes, heart disease, stroke, spinal disorders, neurological conditions, or connective tissue disorders?

☐ yes ☐ no

Please list family member and condition

Do you smoke?

☐ yes ☐ no

Do you drink alcohol?

☐ yes ☐ no

Do you drink caffeine?

☐ yes ☐ no

Do you exercise regularly?

☐ daily ☐ few times/week  
☐ weekly ☐ no

Are you on a special or restricted diet?

☐ yes ☐ no

### Health Conditions

#### Musculoskeletal

- |   |                                       |  |
|---|---------------------------------------|--|
| <input type="radio"/> No musculoskeletal complaints | <input type="radio"/> Ankle Pain      | <input type="radio"/> Connective Tissue Disorder |
| <input type="radio"/> Elbow Pain                    | <input type="radio"/> Fracture        | <input type="radio"/> Gout                       |
| <input type="radio"/> Hip Pain                      | <input type="radio"/> Knee Pain       | <input type="radio"/> Osteoporosis/Osteopenia    |
| <input type="radio"/> Previous Spinal surgery       | <input type="radio"/> Scoliosis       | <input type="radio"/> Shoulder Pain              |
| <input type="radio"/> TMJ Pain                      | <input type="radio"/> Wrist/Hand Pain | <input type="radio"/> Arthritis                  |

#### Neurological

- |  |  |  |  |
|--|--|--|--|
| <input type="radio"/> No Neurological Complaints | <input type="radio"/> Anxiety Disorder | <input type="radio"/> Carpal Tunnel Syndrome | <input type="radio"/> Depression                 |
| <input type="radio"/> Difficulty Concentrating   | <input type="radio"/> Dizziness        | <input type="radio"/> Headache/Migraine      | <input type="radio"/> Loss of taste/vision/smell |
| <input type="radio"/> Memory Issues              | <input type="radio"/> Numbness         | <input type="radio"/> Stroke                 | <input type="radio"/> Pins and needles           |
| <input type="radio"/> sleeping issues            | <input type="radio"/> stroke           | <input type="radio"/> weakness               |  |

#### Head (Ears, Nose, and Throat)

- |  |  |   |  |
|--|--|---|--|
| <input type="radio"/> No Head/ENT Complaints | <input type="radio"/> Blurred or double vision | <input type="radio"/> Cataracts           | <input type="radio"/> Chronic ear infections |
| <input type="radio"/> Dental/gum problems    | <input type="radio"/> Eyeglasses/contacts      | <input type="radio"/> Glaucoma            | <input type="radio"/> Nose Congestion        |
| <input type="radio"/> Postnasal drip         | <input type="radio"/> Hearing loss             | <input type="radio"/> Ringing in the ears | <input type="radio"/> Sore throat            |
| <input type="radio"/> Swollen lymph nodes    | <input type="radio"/> TMJ problems             |   |  |

## Cardiovascular

- ☐ No cardiovascular complaints
- ☐ Chest pain/tightness
- ☐ Coronary artery disease
- ☐ High blood pressure
- ☐ Lower extremity swelling
- ☐ Varicose veins
- ☐ Arrhythmia/irregular heartbeat
- ☐ Congenital heart defect
- ☐ Excessive bruising
- ☐ High cholesterol
- ☐ Palpitations
- ☐ Blood clots
- ☐ Congestive heart failure
- ☐ Heart attack
- ☐ Low blood pressure
- ☐ Shortness of breath

## Respiratory

- ☐ No respiratory complaints
- ☐ Hay fever
- ☐ Sleep apnea
- ☐ Asthma
- ☐ Persistent cough
- ☐ Snoring issues
- ☐ Blood in sputum
- ☐ Pneumonia
- ☐ Wheezing
- ☐ Emphysema
- ☐ Shortness of breath

## Gastrointestinal

- ☐ No gastrointestinal complaints
- ☐ Bloating
- ☐ Colon cancer/polyps
- ☐ Food Sensitivities
- ☐ Irritable bowel syndrome
- ☐ Nausea/vomiting
- ☐ Ulcers
- ☐ Abdominal pain
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Gastric reflux/heartburn
- ☐ Jaundice
- ☐ Pancreatitis
- ☐ Black/bloody stools
- ☐ Colitis
- ☐ Crohn's disease
- ☐ Hemorrhoids
- ☐ Liver disease
- ☐ Diarrhea

## Endocrine

- ☐ No endocrine complaints
- ☐ Hot/cold intolerance
- ☐ Increased urination
- ☐ Testosterone deficiency
- ☐ Cushing's syndrome
- ☐ Hyperparathyroidism
- ☐ Pancreatic conditions
- ☐ Diabetes
- ☐ Hyperthyroidism
- ☐ Purple striae
- ☐ Excessive thirst
- ☐ Hypothyroidism
- ☐ Steroid treatment

## Dermatological/Hematological

- ☐ No dermatological/hematological complaints
- ☐ Eczema
- ☐ Gum bleeding
- ☐ Skin cancer
- ☐ Blood in stool
- ☐ Excessive acne
- ☐ Hyper/hypopigmentation
- ☐ Skin trouble/issues
- ☐ Change in hair/nails
- ☐ Hair loss
- ☐ Psoriasis

## For Women Only

- Are you pregnant?
  - ☐ yes
  - ☐ no
- Are you nursing?
  - ☐ yes
  - ☐ no
- Are you taking birth control?
  - ☐ yes
  - ☐ no

*I consent to a professional and complete chiropractic examination and to any radiographic examinations that the doctor deems necessary. I understand that any fee for services rendered is due at the time of service and cannot be deferred to a later date.*

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Patient/Parent/Guardian Signature

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Date

## QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name \_\_\_\_\_

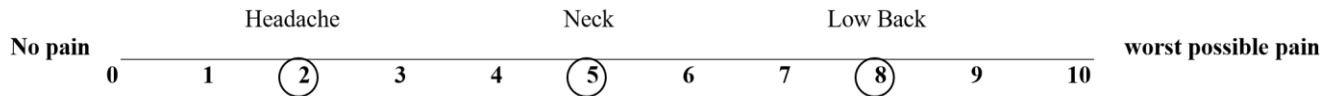
Date \_\_\_\_\_

**Please read carefully:**

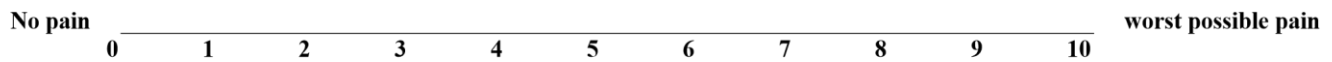
**Instructions:** Please circle the number that best describes the question being asked.

**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.

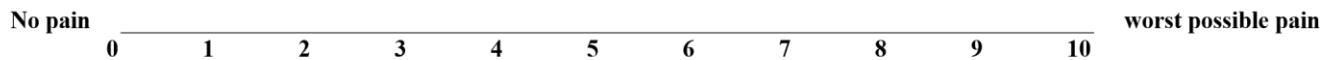
**Example:**



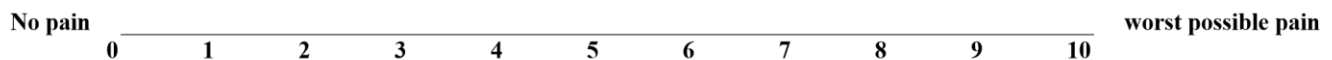
**1 – What is your pain RIGHT NOW?**



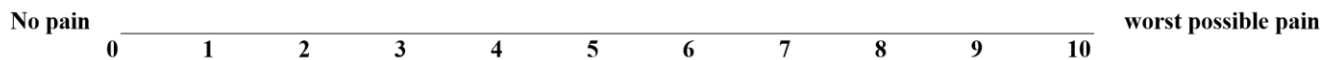
**2 – What is your TYPICAL or AVERAGE pain?**



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



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



**OTHER COMMENTS:**

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Examiner \_\_\_\_\_

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

## **Patient Questionnaire and Informed Consent for Soft Tissue Services (IASTM and cupping.)**

Printed Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please answer the following questions by circling **Yes or No**.

If you have any questions, please speak with your healthcare provider.

- |   |     |    |
|---|-----|----|
| 1. Do you bruise easily?  | Yes | No |
| 2. Do you bleed for a long period of time after you cut yourself? | Yes | No |
| 3. Are you taking any blood thinners or anticoagulants?           | Yes | No |
| 4. Do you take aspirin on a regular basis?                        | Yes | No |
| 5. Do you take cortisone on a regular basis?                      | Yes | No |
| 6. Have you ever had inflamed veins or blood clots?               | Yes | No |
| 7. Do you have surgical implants in your body?                    | Yes | No |
| 8. Do you have diabetes or kidney disease?                        | Yes | No |
| 9. Do you currently have any infections?                          | Yes | No |
| 10. Do you have uncontrolled high blood pressure?                 | Yes | No |
| 11. Have you suffered from a stroke before?                       | Yes | No |

- Instrument Assisted Soft Tissue Mobilization (IASTM) is an instrument-assisted variation of traditional cross fiber or transverse friction massage. The instruments consist of stainless-steel instruments, varying in size and shapes. Using these tools is a form of treatment used to “break-up” or “soften” scar tissue, thus allowing for more return of normal function in the area being treated.

- Myofascial Cupping Therapy is the concept of skin/fascial decompression to help improve tissue mobility which helps improve movement and pain modulation. The soft tissue is suctioned inside the cups, allowing for fluid movement and nutrient supply to the tissues. Cupping improves circulation and aids in draining lymph fluid. These techniques may produce the following:

1. Local discomfort during the treatment
2. Reddening of the skin
3. Superficial Tissue bruising. Cupping produces red or purple circular marks that may last up to 7-14 days
4. Post treatment soreness

In accordance to cupping, avoiding exposure to hot showers, baths, or saunas, hot tubs, and aggressive exercise for at least 24 hours to allow time for cupping to release or settle.

The techniques being used are designed to minimize discomfort; however, the above reactions are normal, and in some instances desirable and unavoidable. All components of IASTM and cupping have been explained to me and I understand the risks of the procedures and I give my full consent for the treatment.

Signature of Patient or Parent/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Patient or Parent/Legal Guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_

# Advanced Beneficiary Notice (ABN)

## Wellness/Maintenance Care



Insurance companies do not pay for everything, even some care that you or your healthcare provider have good reason to think you need. Your insurance will not pay for Chiropractic Maintenance/Wellness or services deemed medically unnecessary per insurance.

Verbiage your insurance company may use to describe medically unnecessary treatment may include some of the following:

- Continued chiropractic care for the same of similar condition would not be considered medically necessary.
- Treatment will not be covered when you have recovered from the **ACUTE** stage of an illness or Injury.
- Treatment for a chronic condition if there is no **reasonable** expectation of improvement.
- Treatment to prevent a relapse or exacerbation (maintenance) of a condition.
- Treatment provided on a routine schedule, even if intended to maintain optimal function.
- Services provided after visit allotment per insurance verification/doctor's discretion.

This notice is to inform you of possible non-covered services that you may be responsible for payment.

Any services deemed not medically necessary or unpaid by your insurance, will be discounted to our cash fees.

Upon signing this notice, I am declaring that I fully understand what has been described above and agree to pay all uncovered services. I fully understand that my insurance company will no longer be billed for treatment received and I cannot appeal to see if my insurance will pay for said treatment.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# Informed Consent to Chiropractic Care



When a person seeks chiropractic care, it is essential for both the individual and the chiropractor to be working towards the same objective.

Chiropractic care has one goal, to correct vertebral subluxations. It is important that each person understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

**Vertebral Subluxation:** A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of the nerve function and interference to the transmission of mental impulses, resulting in a decrease in the body's innate ability to express its maximum health potential.

**Adjustment:** An adjustment is a specific application of forces to facilitate the body's correction of a vertebral subluxation. Our method of correction is by specific adjustments of the neurospinal system.

**Health:** A state of optimal physical, mental, and social wellbeing, not merely the absence of symptoms.

I understand that my care at this office will be focused on the detection and correction of vertebral subluxations. I hereby request and consent to the performance of chiropractic adjustments and assessments. Understanding that everybody has a different potential for wellness thus, the maximal results I will receive in this office cannot be predicted or guaranteed.

Chiropractic care is considered to be one of the safest and most effective forms of care. I understand and am informed that unlike many other health care professions, the risk associated in receiving chiropractic care is extremely minimal. In recent years there have been rare incidents or injury to the vertebral artery during the course of care by medical doctors, physiotherapists and chiropractors. To put this in perspective, the risk of stroke in the general population is 0.00057%. The risk of stroke after a chiropractic adjustment is 0.00025%. The risk of death from taking an aspirin and/or other anti-inflammatory drugs is 0.04%.

It is not our goal or intention to diagnose, treat or attempt to cure any physical, mental, or emotional symptoms. Our expertise is in health, wellness, healing and human physiology. However, if during the course of chiropractic care, we encounter unusual findings, we will bring these to your attention. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Please discuss care alternatives with the attending chiropractor.

**Our primary goal is to release life in the body, through the detection and correction of vertebral subluxations.**

At Lockhart Chiropractic, the privacy of your personal information is an essential part of our office providing you with quality care. We are committed to collecting, using and disclosing your personal information responsibly. Our office has a privacy policy that complies with federal law, which you may view at any time by asking our staff.

I \_\_\_\_\_ have fully read and understand the above statement.  
(PRINT PATIENT'S NAME)

I have also had an opportunity to ask questions about its content. I therefore accept chiropractic assessments and care on this basis. I intend this consent form to cover the entire course of my care in this office with Dr. Edward Lockhart III or other attending chiropractors.

\_\_\_\_\_  
(SIGNATURE)

\_\_\_\_\_  
(DATE)

\_\_\_\_\_  
(WITNESS)

## CONSENT TO ASSESS AND ADJUST A MINOR:

I \_\_\_\_\_, being the parent or legal guardian of \_\_\_\_\_ have  
(PARENT/GUARDIAN NAME) (CHILD'S NAME)

read and fully understand the above terms of acceptance and hereby grant permission for my child to receive a chiropractic assessment and chiropractic care.

# **HIPAA NOTICE OF PRIVACY PRACTICES**



**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that relate to your past, present, or future physical or mental health or condition and related care services.

## **Use and Disclosures of Protected Health Information:**

Your protected health information may be used and disclosed by your physician, our staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital administration.

**Healthcare Operations:** We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, fundraising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to your when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

## **OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.**

You may review this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

**I authorize any representative from Lockhart Chiropractic to discuss or release information regarding my care and billing:**

☐ Full Access

☐ Declined

With the following individual(s): \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

## Pregnancy Release

I do hereby state that, to the best of my knowledge, I am not pregnant. I also state that pregnancy is neither suspected nor confirmed at this time. I do hereby release Lockhart Chiropractic from any liability and authorize them to complete any x-ray examination they deem necessary.

Patient (Parent or Guardian) Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Social Media/Reminder/Marketing Authorization and Releases

The Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my Protected Health Information. I hereby give permission to Lockhart Chiropractic to use and/or disclose Protected Health Information in accordance with the following (*cross off any you do not give consent for*):

### Specific Authorizations:

- I give permission to Lockhart Chiropractic to use my address, phone number, e-mail address and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information.
- If Lockhart Chiropractic contacts me by phone, I give them permission to leave a phone message on my answering machine/voicemail or with the person who answers the telephone at home, work, or cell number I have provided.
- I give permission to Lockhart Chiropractic to use my name on a welcome board, referral board and birthday board.
- I give permission to Lockhart Chiropractic to use my photograph on their waiting room slideshow, patient of the month gallery and other marketing materials such as their brochure, website, social media and ads in print media.
- I give permission to Lockhart Chiropractic to use any testimonial written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochure, on social media, patient of the month gallery and ads in print media.
- I give Lockhart Chiropractic permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.
- By signing this form, you are giving Lockhart Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. This authorization will remain in effect for the duration of my care at Lockhart Chiropractic plus 7 years or until revoked by me.

I have read and consent to the Lockhart Chiropractic's Specific Authorization policies.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# Office Policies

**Cancellation/No-Show Policy:** We are committed to offering the best service to everyone who needs our services. Therefore, we require a minimum 24-hour cancellation notice on all appointments, unless in cases of emergency. **We will bill you \$55 for each missed appointment if not cancelled within 24 hours (at doctor's discretion).**

**Late & Rescheduling:** Please arrive on time for your appointment. If you know you will be late, please call to verify that the doctor will be able to devote your full scheduled time to you. If it is best, we will reschedule your appointment.

**Need Extra Time?:** If you think of other problems you wish us to work on during your appointment, please let us know and we will be happy to schedule additional time for your next appointment.

**Insurance:** Your insurance is an agreement between you and your insurance company. We offer a complimentary benefits check to verify coverage; however, the **benefits quoted to us by your insurance company are not a guarantee of payment.** You are responsible for payment of any non-covered services, deductibles or co-pays. Please notify us if your carrier or policy has changed.

**Non-Participating or "Out of Network:"** It is the responsibility of the patient to verify whether Lockhart Chiropractic contracts with your insurance plan. Any outstanding balances are the responsibility of the patient.

**Account Balance:** Unless Lockhart Chiropractic has an active financial payment agreement on file for you, account balances may not exceed \$200.00.

**Self-Pay/Uninsured:** We understand not everyone has chiropractic coverage. A discount can be applied when you pay on the same day as the treatment given, but not to supplies used. *Once the discount is given, it cannot be billed to an insurance company.*

**Injury/Worker's Compensation:** If your condition is due to an injury, please let us know on your first visit in the clinic and give us any billing information. If we do not receive the billing information on your first visit, the full amount will become your responsibility. We do not accept third party billing or attorney assignments

*I have read, understand, and agree to Lockhart Chiropractic Clinic's Office Policies.*

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Patient Signature

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Date