NEW PATIENT INTAKE INFORMATION

Name and Address of Office:

Barnes Family Chiropractic
227 S. 14th Street
Burlington, CO 80807

Name of Doctor Treating This Patient:

Jason Barnes, DC

Please initial below after reading:

_____ I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named herein and/ or other licensed doctors of chiropractic 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 herein, including those working at the clinic or office listed or any other office or clinic.

I understand I will have an opportunity to discuss with the doctor of chiropractic named and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to: fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor 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.

_____ We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. 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.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

For Women:

_____I understand that x-ray can be hazardous to an unborn child. I certify that I am **not** pregnant.

Date of last menstrual period :___/___/___

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

Signature: _____

***If** signing on behalf of patient/minor child please indicate relationship to patient* Date

Name of Patient: _____

Witness: _____

Patient name: _____
Dr. Signature: _____

FINANCIAL POLICY

Financial responsibility is an important aspect of your health care. Just as Dr. Barnes respects your time as a patient you are expected to respect his time with your payments. In order to keep overhead costs to a minimum it is important that all services be paid for at the time of the office visit. Thank you.

Please initial

____ I understand that payment is due at the time of the office visit. The first office visit is payable in full at the time of service. If a payment schedule needs to be established, immediately notify the front desk staff.

Payment Plan Attached *Staff initial:* _____

FORMS OF ACCEPTED PAYMENT:

***Cash *Check *Money Order *Credit Card: Master card, Visa, or Discover**

PENALTY'S

_____ I understand that unpaid fees for services beyond 60 days are subject to a 2.0 % finance charge (24% annually). I understand a minimum interest of $2.00 per statement may apply.

____Returned checks are subject to a $25 fee.

It is the policy of Barnes Family Chiropractic to assess a **$45.00** missed visit fee to patients who cancel appointments with less than a 24-hour notice. One missed visit will not result in the assessment of a fee. We reserve the right to charge for any additional missed visits. This clinic provides care for many individuals and missed visits result in time lost that could have been used to provide care for others.

_____I understand the missed appointment policy.