Loftis Manual Therapies

Client Information

Name____ Date_________
Birth Date_________________
Email address:____

Address____
Home Phone______________ Work Phone________________Cell________________
(Please circle the phone number that is best to reach you during our office hours.)
How did you discover our office?____
Reason for consulting our office today:____

Please list any concerns in order of importance:
1._______________________ 2. ________________________ 3.________________________

Have you seen any other professionals for these concerns? Y N
If yes, describe the treatment and any results:
____
Have you ever been to a Chiropractor or PT before? Y N When____________________
What were the results?____
Why did you stop going?____
Do you take daily Medications? ____
____
Is there anything else that we need to know about you that was not addressed on this form?
____

Payment Policy

Payment is due at the time of, or previous to, services being rendered. If you have insurance you may be reimbursed for part of your expenses at our office.

We ask that you kindly give 24 hours notice to change an appointment. Office policy is that missed appointments that are not canceled or rescheduled with 24 hours' notice are subject to a $35 fee for each 30-minute time period scheduled.

Informed Consent

Your examination will determine how your neuro-musculoskeletal system is functioning. Treatment is aimed at restoring proper function to dysfunctional areas. The goal of Sports Medicine care is to treat imbalances and dysfunctions in the somatic nervous system (the part of the peripheral **nervous system** associated with the voluntary control of body movements via skeletal muscles.) By restoring proper function to the body, it is more likely to heal itself, however exactly what benefits you will receive, no one can predict.

There are risks that have been reported to be associated with Sports Medicine care. Such risks include, but are not limited to increased pain post-treatment, fractures, dislocation, bruising, stroke, and other neurological complications. However, these incidents are extremely rare and the clinician will use his best judgment to try to avoid any negative events. The most common adverse effect that you might experience is muscle soreness.

By my signature, I acknowledge that there are risks inherent in receiving Sports Medicine care and I give the clinician permission to perform a complete examination and deliver treatment to me. I also acknowledge that the information I have provided is complete and accurate to the best of my ability.

Privacy Notice

Your health information is private and protected by law. Your information will only be used or disclosed for the purpose of giving care, billing, or supporting day-to-day operations. You have the right to review your file. You may restrict all or part of your health information from being released. Our privacy manual is available at any time for you to review. A more detailed privacy policy is available that you may take with you upon request.

Each practitioner at Advanced Health Clinic, L.L.C. is a private contractor and works separately. However, situations sometimes arise when a client may benefit from the services of more than one practitioner. In the event this is true of me, I allow other practitioners to review my file and/or discuss my health needs with me or my therapist.

I have had a chance to ask questions about the privacy policy and I give my permission to this office to disclose my name and, or protected health information in accordance with such policies.

__________________________________ ____________________________________
Name Signature

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Date