



(Please Print)

Date: ___/___/___ Name: _____ Birthdate: ___/___/___

Address: _____ City: _____ State: _____ Zip: _____

Home # _____ Work #: _____ Cell#: _____ Preferred: _____

Email Address: _____ Social Security #: _____ - _____ - _____

Occupation: _____

Sex: F M Marital Status: M S D W Spouse's Name: _____

Name(s) of Children & ages: _____

WHAT ARE YOUR SYMPTOMS?

1. _____ 2. _____

3. _____ 4. _____

When did your symptoms appear? _____ How often? _____

Rate the severity of the pain on a scale of 1(least pain) to 10(severe pain) _____

Type of Pain ___Sharp ___Burning ___Dull ___Throbbing ___Numbness ___Aching
___Shooting ___Tingling ___Cramps ___Stiffness ___Swelling Other: _____

Does it interfere with your: ___Work ___Sleep ___Daily Routine ___Recreation

Activities or movements that are painful: ___Sitting ___Standing ___Walking ___Bending
___Lying Down ___Driving ___Turning Head ___Twisting

Signature of Patient, Parent, Guardian or Personal Representative / **PRINT**

Date: ___/___/___ Relationship to Patient _____

Insurance

Who is responsible for this account? _____ Relationship to Pt. _____

Insurance Company: _____ Group # _____

Is Pt covered by additional Ins? Y N Subscriber's Name: _____

DOB ___/___/___ SS# _____ - _____ - _____ Relationship to Pt: _____

Insurance Company _____ Group # _____

Assignment and Release

I certify that I, and or my dependant(s) have insurance coverage with _____
and assign directly to Dr. Haney Armaly, D.C. all insurance benefits if any, otherwise payable to me for services rendered.

I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. Haney Armaly may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for retained services. The consent will end when my current treatment plan is completed or one year from the date signed below.

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal: to eliminate misalignments within the spinal column which interferes with the expression of the body's innate wisdom. It is important that each patient understand both the objective and the method that will be used to attain our goal. This will prevent any confusion or disappointment.

Adjustment: the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is specific adjustments of the spine.

Health: a state of optimal physical, mental and social well-being, not merely the absence of diseases or infirmity.

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

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 CHIROPRACTIC OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I _____ read and fully understand the above statements.
(Print name)

All questions regarding the doctor's objectives pertaining to my care in the office have been answered to my complete satisfaction.

I, therefore, accept chiropractic care on this basis.

(Signature)

(Date)

Privacy Policies and Office Policies

- Our office will hold your personal information in strict confidence and it will not be released or used in any way without your written permission. Your information is secure and is used only in submitting claims to third party carriers for payment of services and for internal office needs.
- Our office may call you and leave a message on your home phone if it is necessary to contact you regarding an appointment or your care at our office.
- Our office may send you seasonal cards or birthday cards.
- A family member may be present when hearing the results of your exams and tests.
- Our office has an open adjusting environment.
- Our office may write your name on the referral board or on the referral wall.
- Our office may ask you to write a testimonial with your signature on it so we can put it in our office for patients to read.
- Our office may take your picture and put it in our office for being patient of the month.
- We would like to be in communication with your Primary Care Physician about your care here. If this is OK with you then please provide us with his Name & Phone number otherwise write No in this area. _____

Please read above statements and sign that you have been notified of our privacy policies. You have the right to revoke your agreement to our policies at any time in writing. A copy of our policies is available for your convenience.

I have read and agree to the above statements.

Patient Signature

Date