VITALITY CHIROPRACTIC

7216 Wellington Drive Suite 3
Knoxville, TN 37919
Phone: (865) 588-5734
Fax: (865) 588-5738
www.thevitalitychiropractic.com

PATIENT INFORMATION

NAME:_____
LAST FIRST

_____
MI NICKNAME

STREET:_____

_____

CITY:_____

ST:_____ZIP:_____

DOB:_____ SEX: M F

SSN:_____

LANGUAGE: English French Spanish

RACE: American Indian/Alaskan Native
Asian
Black/African American
Native Hawaiian/Other Pacific Islander
White

ETHNICITY: Declined
Hispanic/Latino/Spanish Origin
No Hispanic/Latino/Spanish Origin
Unknown

EMPLOYMENT: Employed Full-time Student
Part-time Student Not Employed
Retired

MARITAL STATUS: Single Married
Divorced Separated
Widowed

How did you hear about our office?

_____

CONTACT INFORMATION

EMAIL:_____

CELL:_____

CELL CARRIER:_____
MUST HAVE FOR TEXT REMINDERS

HOME:_____

WORK:_____

EMERGENCY CONTACT

NAME:_____

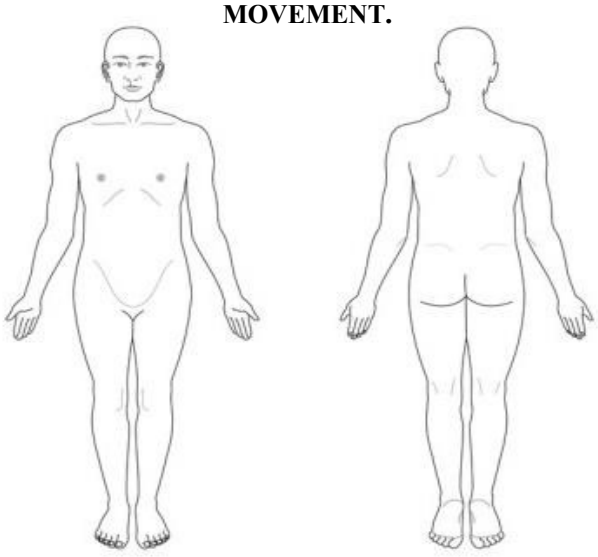
PHONE:_____

RELATION:_____

INSURANCE INFORMATION

FILING: Medical Insurance
Auto Insurance
Workman's Compensation
Attorney

PLEASE INDICATE WHERE YOU EXPERIENCE PAIN, DISCOMFORT AND/OR RESTRICTED MOVEMENT.



CONSENT OF TREATMENT

I acknowledge I am not pregnant and/or do not plan to become pregnant within 30 days of signing this consent. I authorize Vitality Chiropractic permission to render any/all treatment necessary to care for my condition and release Vitality Chiropractic from any/all liability.

Patient Signature:_____Staff Signature:_____

REFUSAL OF X-RAY

I acknowledge I am pregnant and/or do not authorize Vitality Chiropractic permission to x-ray. I understand that refusal to such service may prohibit Vitality Chiropractic's ability to properly care for my condition. I do authorize Vitality Chiropractic permission to render any/all other treatment necessary and release Vitality Chiropractic from any/all liability.

Patient Signature:_____Staff Signature:_____

CONSENT OF TREATMENT OF MINOR/CHILD

I, the legal parent/guardian/custodian of _____, age _____,
PATIENT FULL NAME

authorize Vitality Chiropractic permission to render any/all treatment deemed advisable and/or required. It is the understanding, of the undersigned, that Vitality Chiropractic will have full authority, by me, to continue with any/all treatment necessary until said minor has attained legal age and release Vitality Chiropractic from any/all liability. I, legal parent/guardian/custodian acknowledge and accept full responsibility for any/all charges and payments due to Vitality Chiropractic.

Guardian (Print Name):_____Relation:_____

Guardian Signature:_____Date:_____

AUTHORIZATION

I authorize Vitality Chiropractic permission to release any/all information, diagnosis and/or records of treatment rendered to me, and/or my dependent(s), to documented third party payers and/or insurance companies. I instruct any/all third-party payers and/or insurance companies to pay Vitality Chiropractic directly unless Vitality Chiropractic has instructed otherwise. I acknowledge and assume financial responsibility for any/all remaining charges due to me, and/or my dependent(s), to Vitality Chiropractic should the third-party payers and/or insurance companies not cover and/or pay. I understand, should I not meet my payment responsibilities, I may acquire collection fees and/or attorney fees (up to, but not greater than 20% for each fee) associated with my and/ or my dependent(s), account with Vitality Chiropractic.

Patient (Print Name):_____

Patient Signature:_____Date:_____

Guardian (Print Name):_____Relation:_____

Guardian Signature:_____Date:_____

CANCELLATION POLICY

Our goal at Vitality Chiropractic is to provide quality healthcare to all our patients. We understand your time is valuable, as well as ours. Late arrivals, no shows and/or cancellations not only inconvenience our Doctors, but also the other patients. In the event you are unable to keep your appointment, we do require a 24 hour notice. Should you not comply to this policy, you will be charged a $25 cancellation fee. This does not apply for emergencies.

Patient Signature:_____Staff Signature:_____