PATIENT INFORMATION

Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Sex: __Male __Female Birthdate: _____ Age: ___

__Single __Married __Widowed __Divorced

Employer: _____

Employer Address: _____

_____

Occupation: _____

Spouse/Parent Name: _____

Birthdate: _____

Whom may we thank for referring you?

Is your condition due to an Accident? ____Yes ____No

Type of Accident: __Auto __Work __Other: _____

* Notice to our patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.

_____

SIGNATURE

DATE: _____

PHONE NUMBERS

Home Phone: ( ) _____

Work Phone: ( ) _____

Cell Phone: ( ) _____

Email Address: _____

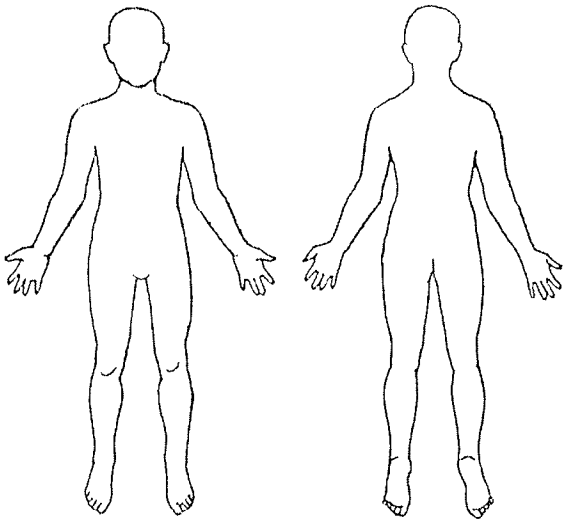
Contact Preference:
__Cell __Home __ Work __Email __Any

Pain Diagram

Please Complete the Following Pain Diagram by using letters to indicate your areas of pain.

P = MAIN PAIN
O = SECONDARY PAIN
T = TINGLING
N = NUMBNESS
B = BURNING
S = STIFFNESS

FRONT **BACK**



Do you know what triggered pain? _____

Does anything relieve it? _____

Does anything aggravate it? _____

Have you had any treatment? _____

History: injuries/Fractures/Surgeries _____

_____

_____

_____

_____

_____

AUTHORIZATION, ASSIGNMENT & RELEASE FORM

In consideration to release of your services for my care, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, adjuster, or referring medical doctor.
2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney out of the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or you based in whole or in party upon the charges made for your services.
3. In event any insurance company, obligated by contractual agreement to make payment to me or to you for the charges made for your services, refused to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent date) and authorize you to prosecute and take action in my name as you see fit. I further authorize you to compromise, settle or otherwise receive any claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, amounts you do not collect from insurance company's proceeds, whether it be all or part of what is due; I personally owe and agree to pay you.
4. In addition to the above, I hereby waive the statute of limitations on collections and/or recovery in this State of LA.
5. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.
6. This Authorization for assignment will be in continual effort until revoked by both parties.
7. I understand that Premier Chiropractic will maintain my privacy to the highest standards.

Patient Signature _____ Date _____

CONSENT TO X-RAY AND/OR PREGNANCY RELEASE

I hereby authorize Premier Chiropractic and whomever the clinician my designate as his/her assistants to take X-rays, and release Premier Chiropractic from any and all liability.

Patient Signature_____ Date_____

CONSENT OF TREATMENT OF MINOR CHILD

I, being the parent/guardian of the minor being _____, age_____, do hereby authorize, request and direct the doctor's office as shown above, it's doctors and staff to perform examinations, diagnostic x-rays, and any treatment that in their judgment, is deemed advisable or required. It is the understanding of the undersigned that the physicians and their staff will have full authority from me as legal parent/guardian to continue with examinations, diagnostic tests and treatments as will be needed while said minor shown above is under care in the office until legal age is attained. As legal parent/guardian I realize full responsibility for all charges and payments due.

Parent/Guardian Signature_____ Date_____

NOTICE OF PRIVACY PRACTICES RECEIPT (HIPPA NPP)

I acknowledge that I was provided with the HIPAA Notice of Provider Privacy Practices revision Nov. 1, 2017 of Premier Chiropractic.

Print Name of Patient:_____ Patient Signature:_____

Date: _____ Patient's Date of Birth:_____

For Personal Representative of Patient (if applicable) Print Name of Representative:_____

Relationship to Patient:_____ Signature or Representative: _____ Date: _____

CONSENT FOR CHIROPRACTIC TREATMENT & ACKNOWLEDGMENT OF RECEIPT OF INFORMATION

To the patient: Every type of health care is associated with some risk of potential problem. Health care providers, including chiropractors, are required, by law, to tell you the nature of your condition, the general nature of treatment the risks involved, and the reasonable therapeutic alternatives.

In keeping with the Louisiana law of informed consent, you are being asked to sign a confirmation that we have discussed all these matters. We have already discussed with you the common problems and risks. Please read this carefully. Ask about anything you do not understand, and we will be pleased to explain it.

In general, chiropractic treatment includes examination, taking of x-rays, manipulation/adjustment, and application of physical therapy modalities. Although their occurrence is extremely remote, some risks are known to be associated with these procedures. These include:

1. Stroke: Stroke is the most serious problem associated with spinal manipulation. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death (1 in 20 million). Spinal manipulations have been associated with strokes that arise from the vertebral artery (located in the neck vertebrae). (This problem occurs so rarely that there is no conclusive data to quantify probablility.)
2. Disc Herniations: Disc herniations that create pressure on the spinal nerve or spinal cord are frequently successfully treated by chiropractor. Rarely, treatment may aggravate the problem, resulting in increased low back pain, radicular pain and numbness of a transient nature. Residuals may last for a few days but seldom for longer periods of time.
3. Soft tissue injury: Soft tissue primarily refers to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely, treatment may injure some muscle and ligament fibers. The result is temporary increase in pain and necessary treatments for resolution, but there are no long term affects for the patient.
4. Rib fractures: The ribs are found only in the thoractic spine or middle back. Rarely, a manipulation will fracture rib bone. This occurs only on patients who have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients carefully, especially those who have indications of osteoporosis on their x-rays.

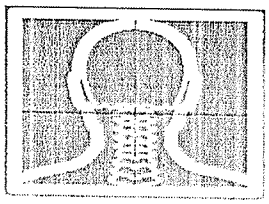
I hereby authorize and direct Premier Chiropractic, together with associates and assistants of his choice, to provide chiropractic treatment including examination/diagnostics, spinal manipulation/adjustment, various modes of physical therapy, x-rays and any additional procedures or services that may be deemed necessary or reasonable. This treatment has been explained to me, and alternative methods of treatment (if any) have also been addressed. I have read and understood all information set forth in this document, including any attachments. I acknowledge that I have had the opportunity to ask any questions about the contemplated procedure and that my questions have been answered to my satisfaction. This authorization for and consent to chiropractic treatment is and shall remain valid until revoked.

Signature of
Patient/Guardian_____Date_____

Printed Name: _____

I certify that I have provided and explained the information set forth herein, including any attachments, and have answered all questions concerning proposed treatment to the best of my knowledge and ability.

Signature of Chiropractic Physician _____Date_____



Premier Chiropractic

Massage Intake Form

NAME _____ TODAY'S DATE _____

PHONE NUMBER _____ DATE OF BIRTH _____

Have you had a professional massage before? Y N Have you had an adjustment before? Y N

What are the expectations of the service you are receiving?

_____

Do you experience any difficulty lying on your front or back? Y N explain_____

Is there an area you would like more time spent or hold tension? _____

Do you have sensitive skin? Y N If so, please list any issues you experience_____

Do you have any allergies or sensitivities to Essential Oils or lotions? Y N If so, explain_____

Are you pregnant? Y N If yes, how far along? _____

Do you smoke? Y N If yes, how often? _____ Do you drink alcohol? Y N If yes, how much? _____

List any surgeries or fractures _____

List any medications you take _____

List any allergies_____

Please check if you have any of the following:

Epilepsy or seizures____High or low Blood Pressure____Cancer____On Blood thinners___Asthma_____Respiratory conditions___Heart Disease___Arteriosclerosis___Varicose Veins___Phlebitis ___Diabetes ___HIV___Herpes___Arthritis ___Hepatitis ___Inner Ear___Epstein Barr ___Fibromyalgia___ Chemotherapy ___Radiation ___Chronic Fatigue ___ Lupus ___ Headaches ___Herniated Disc___Open Sores___Skin Rash___Easy bruising___Osteoporosis___

I understand that the massage I receive is provided for the basic purpose of relaxation, stress reduction, and relief of muscular tension. I understand that **Essential Oil** use is a natural, holistic therapy and not intended to treat, diagnose and/or cure any medical issues. I will keep the massage therapist updated on any changes to my physical and medical condition and medication. By signing this release, I hereby waive and release my therapist and Premier Chiropractic, LLC from any and all liability, past, present, and future relating to massage therapy and **essential oil** use.

Because our Massage Therapists are paid by commission, we ask that you give a 24 hour cancelation notice. **If you are unable to give a 24 hour notice, you may be assessed a $25 fee.**

PATIENT SIGNATURE _____ DATE _____

Premier Chiropractic
1120 North Causeway Blvd. Suite 2
Mandeville, LA 70471
Telephone (985) 674-5855
Fax (985) 674-5854

Notice of Cancellation Policy & No Show Fees for Appointments

Date: _____

Patient Name: _____

At Premier Chiropractic we remind our patients of their appointments several times beforehand either by text, email or phone call. We realize that life is not always predictable and understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. If you cannot make your appointment, we ask that you contact or leave us a message 24 hours ahead of time to cancel or reschedule your appointment.

Failure to provide proper notice prevents another patient from receiving care. This has always been a policy of our office, **but due to limited days and times for appointments**. Patients who fail to show up or give a 24 hours' notice will be charged a **$25.00** fee which must be paid prior to seeing Dr. Dutruch.

We thank you for understanding.

I have read and understand the policy Premier Chiropractic has regarding no shows and cancellations.

_____ _____

Signature of Patient/ Legal Guardian Date