SUFFOLK PHYSICAL THERAPY & CHIROPRACTIC, PLLC
NEW PATIENT NO-FAULT INTAKE FORM

Date: _____

First Name: _____ **MI:** _____ **Last Name:** _____

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

Cell: _____ **Work:** _____ **Home:** _____

Sex: _____ **Age:** _____ **Date of Birth:** _____ **Social Security #:** _____

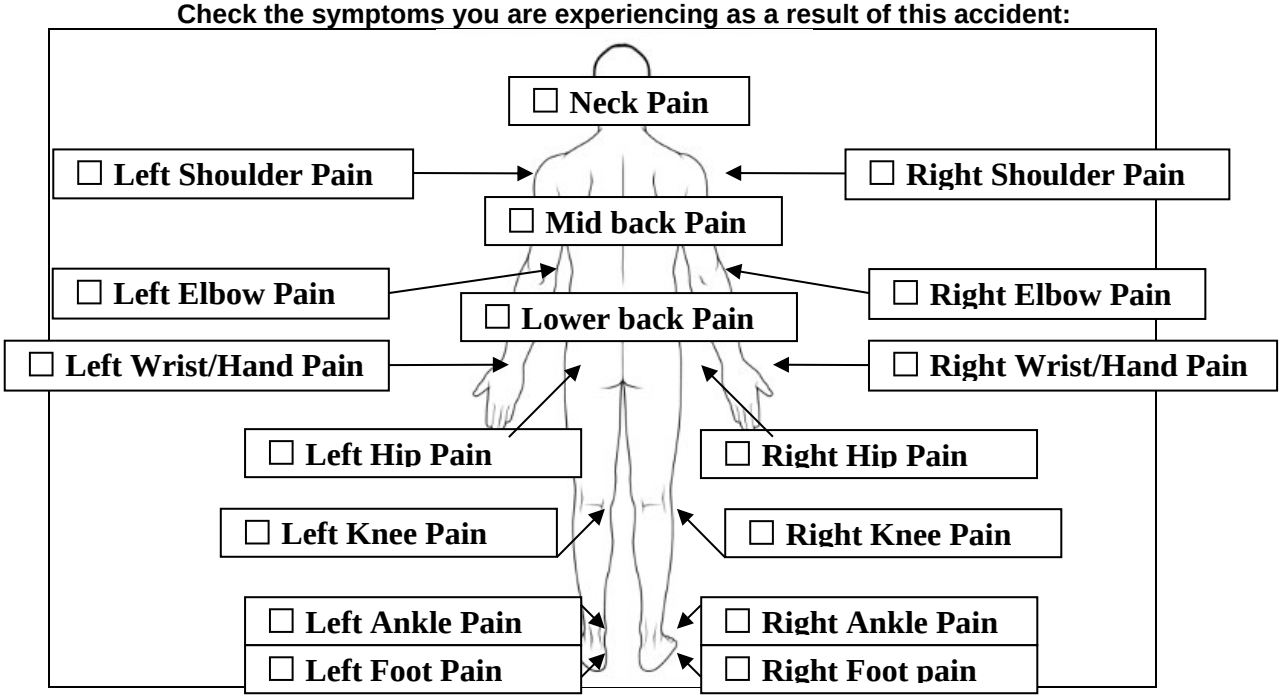
Occupation_____

Date of Accident: _____ **Have you been out of work since the accident?** ☐ **Yes** ☐ **No**

Dates out of work as a result of this accident_____

Did you go to hospital after accident? ☐ **Yes** ☐ **No** **If Yes which one?** _____

Check the symptoms you are experiencing as a result of this accident:



☐ **Headaches** ☐ **Dizziness** ☐ **Memory Loss** ☐ **Blurred vision**
☐ **Ringing in the Ears** ☐ **Difficulty Sleeping** ☐ **Fatigue** ☐ **Jaw Pain**
☐ **Clicking of the Jaw** ☐ **Numb Fingers** ☐ **Numb Toes**
☐ **Chest Pain** ☐ **Nausea** ☐ **Other**_____

INSURANCE INFORMATION;

Insurance Company of car you were occupying or if pedestrian car that hit you and address: _____

_____

Insured's Name: _____ **Relation to you**_____

Insured's Date of Birth: _____ **Insured's SS#**_____

Your Signature_____

HIPPA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carryout treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice, and any other use required by law. Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.
Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission. Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers’ compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your**Rights**

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality. You have the right to request a restriction of your protected health information –This means you may ask us not to use or disclose any part of your protected health information and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications–You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures–You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the “Acknowledgment of Receipt” shown below. You are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Print Name:_____

Signature: _____

Date: _____

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS

DATE	POLICY HOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE NEW YORK NO-FAULT LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

IMPORTANT: **1. TO BE ELIGIBLE FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION.**
2. YOU MUST SIGN ANY ATTACHED AUTHORIZATION(S).
3. RETURN PROMPTLY WITH COPIES OF ANY BILLS YOU HAVE RECEIVED TO DATE.

NAME AND ADDRESS OF APPLICANT

1. YOUR NAME	2. PHONE NOS. HOME	BUSINESS

3. YOUR ADDRESS (NO., STREET, CITY OR TOWN AND ZIP CODE)	4. DATE OF BIRTH	5. SOCIAL SECURITY NO.

6. DATE AND TIME OF ACCIDENT:	7. PLACE OF ACCIDENT (STREET), CITY OR TOWN AND STATE
: A.M. : P.M.	

8. BRIEF DESCRIPTION OF ACCIDENT:

8. DESCRIBE YOUR INJURY:

10. IDENTITY OF VEHICLE YOU OCCUPIED AT THE TIME OF ACCIDENT:

OWNER'S NAME **MAKE** **YEAR**

THIS VEHICLE WAS:

☐ **A TRUCK, OR** ☐ **A BUS OR SCHOOL BUS**
☐ **A MOTORCYCLE** ☐ **AN AUTOMOBILE**

11. WERE YOU THE DRIVER OF THE MOTOR VEHICLE?	☐ YES	☐ NO
WERE YOU A PASSENGER IN THE MOTOR VEHICLE?	☐ YES	☐ NO
WERE YOU A PEDESTRIAN?	☐ YES	☐ NO
WERE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD?	☐ YES	☐ NO
DO YOU OR A RELATIVE WITH WHOM YOU RESIDE OWN A MOTOR VEHICLE?	☐ YES	☐ NO

12. WERE YOU TREATED BY A DOCTOR(S) OR OTHER PERSON(S) FURNISHING HEALTH SERVICES? ☐ **YES** ☐ **NO**

NAME AND ADDRESS OF SUCH DOCTOR(S) OR PERSON(S):

13. IF YOU WERE TREATED AT A HOSPITAL(S), WERE YOU AN: OUT-PATIENT ☐ **IN-PATIENT** ☐

DATE OF ADMISSION: **HOSPITAL'S NAME AND ADDRESS:**

14. AMOUNT OF HEALTH BILLS TO DATE	15. WILL YOU HAVE MORE HEALTH TREATMENTS(S)	16. AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT?	
$_____	☐ YES ☐ NO	☐ YES ☐ NO	
17. DID YOU LOSE TIME FROM WORK? ☐ YES ☐ NO	**DATE ABSENCE FROM WORK BEGAN:**	**HAVE YOU RETURNED TO WORK?** ☐ YES ☐ NO	**IF YES, DATE RETURNED TO WORK:**
AMOUNT OF TIME LOST FROM WORK:	**18. WHAT ARE YOUR AVERAGE WEEKLY EARNINGS?**	**NUMBER OF DAYS YOU WORK PER WEEK:**	**NUMBER OF HOURS YOU WORK PER DAY:**

19. WERE YOU RECEIVING UNEMPLOYMENT BENEFITS AT THE TIME OF THE ACCIDENT? ☐ **YES** ☐ **NO**

(Continued on next page)

BRACKETED LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS
(Page 2)

20. LIST NAMES AND ADDRESS OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

21. AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? ☐ **YES** ☐ **NO**
IF YES, ATTACH EXPLANATION AND AMOUNTS OF SUCH EXPENSES.

22. DUE TO THIS ACCIDENT HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR PAYMENTS UNDER ANY OF THE FOLLOWING

NEW YORK STATE DISABILITY? ☐ **YES** ☐ **NO**

WORKERS' COMPENSATION? ☐ **YES** ☐ **NO**

THE APPLICANT AUTHORIZES THE INSURER TO SUBMIT ANY AND ALL OF THESE FORMS TO ANOTHER PARTY OR INSURER IF SUCH IS NECESSARY TO PERFECT ITS RIGHTS RECOVERY PROVIDED FOR UNDER THE NO-FAULT LAW

THIS FORM IS SUBSCRIBED AND AFFIRMED BY THE APPLICANT AS TRUE UNDER THE PENALTIES OF PERJURY

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

SIGNATURE _____ **DATE** _____

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF WORK AND OTHER LOSS INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF. WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES. SALARY OR OTHER LOSS WHILE EMPLOYED BY YOU. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW)

NAME (PRINT OF TYPE) _____ **SOCIAL SECURITY NO.** _____

SIGNATURE _____ **DATE** _____

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF HEALTH SERVICE OR TREATMENT INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF. WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREA-TMENT. INCLUDING THE HISTORY OBTAINED. X-RAYS AND PHYSICAL FINDINGS. DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

NAME (PRINT OF TYPE) _____

SIGNATURE _____ **DATE** _____

(IF THE APPLICANT IS A MINOR. PARENT OR GUARDIAN SHALL SIGN AND INDICATE CAPACITY AND RELATIONSHIP).

♦ BRACKETED LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, _____, ("Assignor") hereby assign to Suffolk Physical Therapy & Chiropractic, PLLC ("Assignee")
(Print patient's name) (Print hospital or health care provider name)
all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on_____ , not withstanding any other agreement
(Print accident date)
to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

_____ _____
(Print name of Patient) **(Signature of Patient)**

_____ _____
(Date of signature)

_____
(Address of Patient)

_____
(Address of Provider)

_____
(Signature of Provider)

_____ _____
(Date of signature)

_____
(Address of Provider)

NYS FORM NF-AOB (Rev 1/2004)

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, _____ (Print patient's name), ("Assignor") hereby assign to Suffolk Physical Therapy & Chiropractic PLLC (Print hospital or health care provider name) ("Assignee") all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____ (Print accident date), not withstanding any other agreement to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

_____ _____
(Print name of Patient) **(Signature of Patient)**

_____ _____
(Date of signature)

_____
(Address of Patient)

_____
(Address of Provider)

_____
(Signature of Provider)

_____ _____
(Date of signature)

_____
(Address of Provider)

NYS FORM NF-AOB (Rev 1/2004)

ATTORNEY LIEN

To: Attorney:

_____

_____

_____

I do hereby authorize Suffolk Physical Therapy & Chiropractic, PLLC (SPT&C), to furnish you, my attorney/insurance carrier, with a full report of my case history, examination, diagnosis, treatment and prognosis in regard to my accident which occurred on _____

I hereby authorize and direct you, my attorney, to pay directly to SPT&C such sums as may be due and owing SPT&C for professional services rendered to me both by reason of this accident, and by reason of any other bills that are due his office. Such sums owed SPT&C, are to be withheld from my settlement/judgment, or verdict as may be necessary to protect said doctor. I hereby further authorize to be paid to SPT&C immediately upon receipt by you, my attorney, and that such funds owed SPT&C, are not to be held in escrow for ay reason to delay payment to SPT&C. You, my attorney, will also not engage in any negotiations with SPT&C to lower the fees owed, when my settlement is obtained by you. I understand that SPT&C must be paid prior to any fees being released to myself or you, my attorney.

I further understand that I am directly ad fully responsible to SPT&C for all professional bills submitted by SPT&C for services rendered to me and that this agreement is made solely for SPT&C's additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Patient's Name _____ Date _____

Patient's Signature_____

The undersigned, being the attorney of record for the above patient, does hereby agree to observe all he terms off the above and agrees to withhold such sums for any settlement, judgment, or verdict as may be necessary to adequately protect SPT&C named above.

Attorney's Name_____ Date _____

Attorney's Signature_____

PLEASE DATE, SIGN, AND RETURN ONE COPY TO SPT&C'S OFFICE AT ONCE SO THAT WE MAY CONTINUE TREATING YOUR CLIENT.

INFORMED CONSENT

Patient's Name: _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask any questions you may have, prior to signing, if anything is unclear.

The Nature of the Chiropractic Adjustment

As a Doctor of Chiropractic the primary treatment method I use is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or mechanical instruments upon you body in order to move your joints. This may cause an audible "pop" or "click," similarly to what you may have experienced if you "cracked" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As part of the analysis, examination, and treatment, you are consenting to the following procedures.

☐ Physical Examination and Analysis, to include:
Range of motion testing
Muscle strength testing
Palpation
Orthopedic testing
Basic neurological
Vital signs
Postural analysis

☐ Chiropractic Treatment, to include:
Spinal manipulative Therapy
Electric muscle stimulation
Ultrasound
Hot/Cold therapy
Massage therapy
Radiographic studies (x-rays)
other: _____

The Material Risks Inherent in Chiropractic Adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injures to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients may feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The Probability of Those Risks Occurring

Fractures are rare occurrences and generally result from some underlying bone weakness, which I check for during the taking of your history and during the examination and via X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are generally described as rare.

The Availability and Nature of Other Treatment Options

Other treatment options for your condition may include

-Self Administered, Over-the-Counter Analgesics and rest
-Medical Care and Prescription Drugs such as anti-inflammatory, muscle relaxants, and pain killers.
-Hospitalization
-Surgery

Should you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary care physician.

The Risks and Dangers Attendant to Remaining Untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

PLEASE DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read [__] or have had read to me [__] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the doctor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommending. I having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____ **Dated:** _____

Patients Name: _____ **Doctor's Name:** _____

Patients Signature: _____ **Doctor's Signature:** _____

Business Name: Suffolk Physical Therapy & Chiropractic, PLLC

Signature of Parent or Guardian (if a minor): _____