Apple Valley Chiropractic & Rehab
7600 147th St. W. Ste. 100
Apple Valley, MN 55124

Date_____

Patient Name_____ Date of Birth_____

Insurance holder (Guarantor) name_____ Relationship to Patient_____

Marital Status M S W D Separated Ethnicity _____

Address_____ Home Phone #_____
City State Zip

Email address_____ Cell Phone #_____

Employer_____ Work Phone#_____

Emergency Contact Name_____ Phone #_____

☐ I agree to receive SMS messages from Apple Valley Chiropractic By checking the box, you consent to receive appt reminders and promotions via SMS text from Apple Valley Chiropractic at the number provided. Texts will come from 952-431-3003. Msg frequency varies. Consent not required for purchase. Msg & data rates may apply. Reply STOP to opt out. Reply HELP for help. Privacy Policy & Terms: www.applevalleychiropractic.com

Welcome to Apple Valley Chiropractic & Rehab

We make our best effort to accommodate patient appointments as quickly as possible. We also strive to carefully manage our schedule to avoid overbooking and long wait times. This allows us to provide the best patient experience possible in a relaxed environment. In order to accomplish this level of service, we ask that patients handle appointment cancellations and re-scheduling in a respectful manner. We reserve the right to restrict future appointment scheduling if a patient misses three appointments within a three month period without prior notice. Apple Valley Chiropractic & Rehab has a cancellation policy of $15 for massage therapy appointment no shows or appointments cancelled within 12 hours of set appointment time.

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may take the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. **Health** is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity. One disturbance to the nervous system is called a **vertebral subluxation.** This occurs when one or more of the 24 vertebra in the spinal column become misaligned and/or do not move properly. This causes alteration or nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an **adjustment.** An adjustment is the specific application of forces to correct or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

All health care procedures carry some risk. Risks associated with chiropractic care may include, but are not limited to, muscle or ligament injuries, vascular injuries and fractures. Alternatives to chiropractic care may include medications, injections, surgery and other alternative treatments.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care at Apple Valley Chiropractic & Rehab on this basis.

_____ _____ _____
Print Name Signature Date

Consent to evaluate and adjust a minor or child:
I, _____ being the parent or legal guardian of
_____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:
This is to clarify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

_____ _____
Signature Date