Auth Chiropractic Center
114 Village Place, Suite-201
P.O. Box 656
Dillon, CO 80435

AUTH
Chiropractic & Vitality Center

Telephone: (970)262-7929
FAX: (970)262-7971
auth.chiropractic.vitality@gmail.com
www .authchiropractic.com

WELCOME TO OUR OFFICE!

We appreciate you selecting us for your Chiropractic Care. We are dedicated to providing our patients with the highest quality of care available. We understand that the physician/patient relationship is unique and confidential.

We make every effort to see our patients promptly and recognize the value of your time. We apologize for any inconvenience and appreciate your patience. Should any waiting time cause any scheduling conflicts please let the receptionist know immediately so that your appointment can be rescheduled.

GENERAL INFORMATION

We treat patients of all ages for neuro-musculoskeletal (spinal and other nerve or joint) conditions. Our patients are seen by appointment only. However, we will try to accommodate any urgent needs. Please call at least 24 hours before your appointment if you need to cancel so that someone else may take that time.

PAYMENT

Payment is due at time of service. Payment options include: Cash, Check, Debit, Visa or MasterCard.

All sales are final and non-refundable *(this includes supplements, pre-paid plans, chiropractic procedures and The DRS Protocol for non-surgical spinal decompression)*

INSURANCE

There are thousands of insurance plans in the United States. It is impossible for our office staff to know the covered benefits of your insurance plan. As a courtesy to you, we try our best to anticipate the cost of your services after insurance has been billed, although when benefits are checked it is not a guarantee of coverage or payment per your insurance company's policy. Should you exceed or go outside your plan coverage, you are responsible for the charges incurred. Co-pays and/or amount of **estimated** payment should be made at the time of service.

MISSED APPOINTMENTS

Any missed appointments shall be subject to a **$50.00 cancellation fee** unless 24 hours' notice is given. Patients on a Treatment Plan or Pre-Paid Package will have one visit taken from the plan for each missed appointment.

Auto Accident / Workers Compensation Patients: Failure to show for an appointment or to give 24 hours' notice of cancellation for more than 2 appointments (including massage), will result in the closing of your case and being released you from care due to failure to comply with doctor's recommendations and policies.

Directions to Auth Chiropractic and Vitality

If traveling from Frisco/Breckenridge:

-Turn onto Dillon Dam Rd. and travel East.
-At the roundabout take the first right onto W. La Bonte St.
-Follow La Bonte St. through two stop signs.
-After crossing through the intersection of Lake Dillon Drive, immediately turn left into a large parking lot.
-Our office is located in the Dillon Tech. Center- a large four story rust colored building.
-Enter the ground floor, take the elevator to the second floor. Our office is the first door on the right (Suite 201)

If traveling from Keystone/Dillon/Silverthorne:

-Turn off of Highway 6 at the main stoplight in Dillon onto Lake Dillon Drive.
-Drive to the intersection of Lake Dillon Drive and La Bonte St. (first stop sign) and turn left.
-Immediately turn left into a large parking lot.
-Our office is located in the Dillon Tech. Center- a large four story rust colored building.
-Enter the ground floor, take the elevator to the second floor. Our office is the first door on the right (Suite 201)

Welcome

Patient Information

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ 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.

The above-named doctor 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 or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

Phone Numbers

Home Phone (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

Accident Information

Is condition due to an accident? ☐ Yes ☐ No

Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)

_____

Patient Condition

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

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

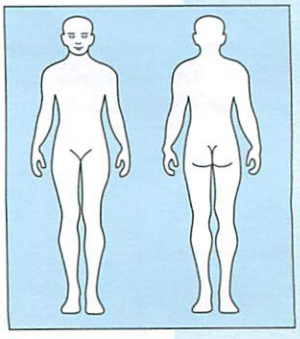
Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down



Health History

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Other _____
Chemical Dependency	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No	_____
Chicken Pox	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No				
		Measles	☐ Yes ☐ No				

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Medications	Allergies	Vitamins/Herbs/Minerals
Pharmacy Name _____		
Pharmacy Phone (____) _____		

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Oswestry for Low Back Pain

Section 1 – PAIN INTENSITY	**Section 6 - STANDING**
☐ I can tolerate the pain I have without having to use pain medication.	☐ I can stand as long as I want without increased pain.
☐ The pain is bad, but I can manage without having to take pain medication.	☐ I can stand as long as I want but it increases my pain.
☐ Pain medication provides me with complete relief from pain.	☐ Pain prevents me from standing for more than 1 hour.
☐ Pain medication provides me with moderate relief from pain.	☐ Pain prevents me from standing for more than ½ an hour.
☐ Pain medication provides me with little relief from pain.	☐ Pain prevents me from standing for more than 10 minutes.
☐ Pain medication has no effect on my pain.	☐ Pain prevents me from standing at all.
Section 2 – PERSONAL CARE (Washing, Dressing, etc.)	**Section 7 – SLEEPING**
☐ I can take care of myself normally without causing increased pain.	☐ My sleep is never disturbed by pain.
☐ I can take care of myself normally, but it increases my pain.	☐ I can sleep well only using pain medication.
☐ It is painful to take care of myself, and I am slow and careful.	☐ Even when I take medication, I sleep less than 6 hours.
☐ I need help, but I am able to manage most of my personal care.	☐ Even when I take medication, I sleep less than 4 hours.
☐ I need help every day in most aspects of my care.	☐ Even when I take medication, I sleep less than 2 hours.
☐ I do not get dressed; I wash with difficulty, and stay in bed.	☐ Pain prevents me from sleeping at all.
Section 3 - LIFTING	**Section 8 – SOCIAL LIFE**
☐ I can lift heavy weights without increased pain.	☐ My social life is normal and does not increase my pain.
☐ I can lift heavy weights, but it causes increased pain.	☐ My social life is normal, but it increases my level of pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (e.g., on a table).	☐ Pain prevents me from participating in more energetic activities. (e.g., sports, dancing)
☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.	☐ Pain prevents me from going out very often.
☐ I can lift only very light weights.	☐ Pain has restricted my social life to my home.
☐ I cannot lift or carry anything at all.	☐ I have hardly any social life because of my pain.
Section 4 - WALKING	**Section 9 - TRAVELING**
☐ Pain does not prevent me from walking any distance.	☐ I can travel anywhere without increased pain
☐ Pain prevents me from walking more than 1 mile. (1 mile = 1.6 km)	☐ I can travel anywhere, but it increases my pain.
☐ Pain prevents me from walking more than 1/2 mile.	☐ My pain restricts my travel over 2 hours.
☐ Pain prevents me from walking more than 1/4 mile.	☐ My pain restricts my travel over 1 hour.
☐ I can walk only with crutches or a cane.	☐ My pain restricts my travel to short necessary journeys under 30 minutes.
☐ I am in bed most of the time and have to crawl to the toilet.	☐ My pain prevents all travel except for visits to the physician/therapist or hospital.
Section 5 - SITTING	**Section 10 - RECREATION**
☐ I can sit in any chair as long as I like.	☐ My normal homemaking/job activities do not cause pain.
☐ I can sit in my favorite chair for as long as I like.	☐ My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
☐ Pain prevents me from sitting for more than 1 hour.	☐ I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities. (eg., lifting, vacuuming)
☐ Pain prevents me from sitting for more than ½ an hour.	☐ Pain prevents me from doing anything but light duties.
☐ Pain prevents me from sitting for more than 10 minutes.	☐ Pain prevents me from doing even light duties.
☐ Pain prevents me from sitting at all.	☐ Pain prevents me from performing any job or homemaking chores.

Name (Printed)_____

Signature_____ Date_____

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Differential Diagnosis for the Chiropractor
Roland - Morris Low Back Disability Questionnaire

Instructions
When your back hurts you may find it difficult to do some of the things you normally do. This list contains some sentences that people have used to describe themselves when they have back pain. When you read them, you may find that some stand out because they describe you *today*. As you read the list, think of yourself *today*. When you read a sentence that describes how you feel *today*, check the box next to it. If the sentence does not describe you, then leave the box blank and go on to the next one. Remember, only check the sentence if you are sure that it describes you today.

	1. I stay home most of the time because of my back.
	2. I change positions frequently to try to get my back comfortable.
	3. I walk more slowly than usual because of my back.
	4. Because of my back, I am not doing any of the jobs that I usually do around the house.
	5. Because of my back, I use a handrail to get upstairs.
	6. Because of my back, I lie down to rest more often.
	7. Because of my back, I have to hold on to something to get out of an easy chair.
	8. Because of my back, I try to get other people to do things for me.
	9. I get dressed more slowly than usual because of my back.
	10. I only stand up for short periods of time because of my back.
	11. Because of my back, I try not to bend or kneel down.
	12. I find it difficult to get out of a chair because of my back.
	13. My back is painful almost all the time.
	14. I find it difficult to turn over in bed because of my back.
	15. My appetite is not very good because of my back.
	16. I have trouble putting on my socks (stockings) because of the pain in my back.
	17. I only walk short distances because of my back pain.
	18. I sleep less well because of my back pain.
	19. Because of my back pain, I get dressed with help from someone else.
	20. I sit down for most of the day because of my back.
	21. I avoid heavy jobs around the house because of my back.
	22. Because of my back pain, I am more irritable and bad tempered with people than usual.
	23. Because of my back, I go upstairs more slowly than usual.
	24. I stay in bed most of the time because of my back.

Rate the severity of your pain by checking one box on the following scale:

0	1	2	3	4	5	6	7	8	9	10

(NO PAIN) (UNBEARABLE PAIN)

SIGNATURE_____ DATE_____

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Oswestry for Neck Disability

Section 1 – PAIN INTENSITY	Section 6 - CONCENTRATION
☐ I have no pain at the moment. ☐ The pain is very mild. ☐ The pain is moderate at the moment. ☐ The paint is fairly severe at the moment. ☐ The pain is very severe at the moment. ☐ The pain is the worst pain imaginable.	☐ I can concentrate fully when I want to with no difficulty. ☐ I can concentrate fully when I want to with slight difficulty. ☐ I have a fair degree of difficulty in concentrating when I want to. ☐ I have a lot of difficulty in concentrating when I want to. ☐ I have a great deal of difficulty in concentrating when I want to. ☐ I cannot concentrate at all.
Section 2 – PERSONAL CARE (washing, dressing, etc.)	**Section 7 - WORK**
☐ I can look after myself normally without causing extra pain. ☐ I can look after myself normally but it causes extra pain. ☐ It is painful to look after myself and I am slow and careful. ☐ I need some help but manage most of my personal care. ☐ I need help every day in most aspects of self-care. ☐ I cannot get dressed; I wash with difficulty and stay in bed.	☐ I can do as much work as I want to. ☐ I can do my usual work, but no more. ☐ I can do most of my usual work, but no more. ☐ I cannot do my usual work. ☐ I can hardly do work at all. ☐ I cannot do any work at all.
Section 3 - LIFTING	**Section 8 - DRIVING**
☐ I can lift heavy weights without extra pain. ☐ I can list heavy weights but it gives extra pain. ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table. ☐ Pain prevents me from lifting heavy weights, but I manage light to medium weights if they are conveniently positioned. ☐ I can lift very light weights. ☐ I cannot lift or carry anything at all.	☐ I can drive my car without any neck pain. ☐ I can drive my car as long as I want with slight pain in my neck. ☐ I can drive my car as long as I want with moderate pain in my neck. ☐ I cannot drive my car as long as I want because of moderate pain in my neck. ☐ I can hardly drive at all because of severe pain in my neck. ☐ I cannot drive my car at all.
Section 4 - READING	**Section 9 - SLEEPING**
☐ I can read as much as I want to with no pain in my neck. ☐ I can read as much as I want to with slight pain in my neck. ☐ I can read as much as I want with moderate pain in my neck. ☐ I cannot read as much as I want because of moderate pain in my neck. ☐ I can hardly read at all because of severe pain in my neck. ☐ I cannot read at all.	☐ I have no trouble sleeping. ☐ My sleep is slightly disturbed (less than 1 hour sleepless). ☐ My sleep is mildly disturbed (1-2 hours sleepless). ☐ My sleep is moderately disturbed (2-3 hours sleepless). ☐ My sleep is greatly disturbed (3-5 hours sleepless). ☐ My sleep is completely disturbed (5-7 hours sleepless).
Section 5 - HEADACHES	**Section 10 - RECREATION**
☐ I have no headaches at all. ☐ I have slight headaches that come infrequently. ☐ I have moderate headaches which come infrequently. ☐ I have moderate headaches which come frequently. ☐ I have severe headaches which come frequently. ☐ I have headaches almost all the time.	☐ I am able to engage in all my recreation activities with no neck pain at all. ☐ I am able to engage in all my recreation activities, with some pain in my neck. ☐ I am able to engage in most, but not all, of my usual recreational activities because of pain in my neck. ☐ I am able to engage in a few of my usual recreational activities because of pain in my neck. ☐ I can hardly do any recreation activities because of pain in my neck. ☐ I cannot do any recreation activities at all.

Name (Printed)_____

Signature_____ Date_____

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OUR FINANCIAL POLICY AND CREDIT CARD AUTHORIZATION CONTRACT

Patient Name:_____

Welcome! We strive to provide our patients with professionalism and excellent service. Our commitment to your well-being is something we take very seriously. We realize it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need to receive and to the actions we require of you. We expect you to keep your appointments. We have a 24-hour cancellation policy if you are unable to keep your appointment. In such a case, please promptly contact our office to reschedule the appointment.

Please be advised in an instance of a cancellation without 24-hour notice or a no-show, we reserve the right to charge a **$50.00 fee or full amount of the services scheduled for.** Missed appointment fees for **massage** therapy services shall be equal to the full session price. The credit card on file will be charged for the full amount. Please avoid this fee by arriving for your scheduled appointments on time!

*__Insurance:__ We do accept Medicare and commercial insurances for chiropractic care. As a courtesy to you, we will contact your insurance company and request your chiropractic benefits. However, this is not a guarantee of payment for any or all of your fees. Payment is due at the time for services provided.
*We do not bill insurance for The DRS Protocol for non-surgical spinal decompression. We will gladly print out a superbill for you to submit to your insurance for reimbursement.**

**__Auto Accident / Workers Compensation Patients:__ Failure to show for an appointment or to give 24-hour notice of cancellation for more than two appointments (including massage), will result in the closing of your case and releasing you from care due to failure to comply with doctor's recommendations and policies.

__Procedures, products and supplements:__ All sales are final and non-refundable (*this includes supplements, pre-paid plans, chiropractic procedures and The DRS Protocol for non-surgical spinal decompression)*
The purpose of this form is to authorize Auth Chiropractic Center to retain a valid credit card number on file for you as our patient. Your supplied credit card will be charged ONLY under the following circumstances:

Auth Chiropractic Center reserves the right to charge the credit card on file for all current patient balances, including services, spinal decompression balances, supplements and supplies. A receipt will be kept in your patient chart, unless directed to send the receipt directly to you. This notice serves as your consent to being charged and accepting responsibility for all current patient balances on your account.

We appreciate you greatly and look forward to providing your wellness-based healthcare needs.

I understand and agree to adhere to the Auth Chiropractic and Vitality Center appointment and financial policy.

_____

Patient Signature **Date**

**Please flip over and fill out/sign other side.

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PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

_____, hereby states that signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent.
2. The Practice reserves the right to change it privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; b) telephoning my home or mobile phone and leaving a message on my answering machine or with the individual answering the phone; and c) sending an electronic reminder via e-mail provided or text message.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on the consent.
7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand to the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____
Name of individual (PRINTED) Signature of Individual

_____ _____
Signature of Legal Representative (e.g. attorney-in-fact, guardian, parent if minor) Relationship

_____ _____
Date signed Witness

_____ _____
(Name and Relationship)-has permission to receive information regarding my records.

_____ _____
(Name and Relationship)-has permission to receive information regarding my records.

* *This form was developed by the AC4 (American Chiropractic Association) and is distributed with their permission.*

** **Please flip over and fill out and sign other side.**

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Informed Consent

I understand that the healing profession is not an exact science, and as such, side effects from examinations and treatments may occur on rare occasions.

I hereby request and consent to the performance of: physical examinations and evaluations and performance of any tests or X-rays required to be performed to diagnose my condition(s), of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, of Decompression, on me (or on the patient named below, for whom I am legally responsible) by or under the supervision of the doctor of chiropractic named below and/or other licensed doctors of chiropractic: who now or in the future treat me while employed by, working, or associated with, or serving as back-up for the doctor of chiropractic named below, including those work at the clinic or office listed below.

I hereby acknowledge the above statement and give my consent to Dr. Jeffrey B. Auth, D.C. to perform the usual, customary, and reasonable chiropractic examinations and treatments on me or my minor dependent child if so noted. *

_____
*Print Patient's Name

_____
Signature of Patient

_____
Print Name of Patient's Representative

_____
Signature of Patient's Representative

_____ _____
Witness to Patient's Signature Date