LIBERATION
CHIROPRACTIC & WELLNESS

Dr. Michael D. Bucknell, D.C.
7921 Tanner Williams Road, Ste B
Mobile, AL 36608
Phone 251.607.0040
Fax 251.607.7202

New Personal Injury Patient Action Plan

Patient Name: _____

1. Your first appointment today will consist of **posture images, examination, insight scan, and x-rays** as the doctor finds necessary. X-rays will then be marked and reviewed by the doctor to review results with you at your second appointment (typically 24 hours turnaround).
2. Your second appointment the doctor will review what he found on your x-rays, you will receive your **first adjustment, and if there are any additional tests or x-rays** needed to determine the best course of care, the doctor will order.
3. After your second appointment, your Dr. may find it necessary to order a Digital Motion Xray. If necessary, this appointment will be scheduled before your review.
4. Your review appointment is the most important visit you will have; the doctor will go through all of your x-rays, findings, and offer **recommendations on course of care**. There is NO cost for this visit.

Lawyer's Contact Info:_____

Your coverage has been confirmed with your lawyer on:_____

Your DMX has been confirmed with your lawyer on:_____

Your home care equipment has been approved by your lawyer on:_____

Letter of Protection received:_____

Date: _____ Time: _____

Date: _____ Time: _____

Signature: _____

Witness: _____

LIBERATION
CHIROPRACTIC & WELLNESS

PERSONAL INJURY APPLICATION FOR CARE AT LIBERATION CHIROPRACTIC & WELLNESS, PC

Today's Date: _____ HRN: _____

PATIENT DEMOGRAPHICS

Name: _____Birth Date: _____-_____-_____ Age: _____ o Male o Female

Address: _____City: _____ State: _____ Zip: _____

E-mail Address: _____ Home Phone: _____Mobile Phone:_____

Marital Status: q Single q Married Do you have Insurance: q Yes q No Work Phone:_____

Social Security #: _____Driver's License #:_____

Employer: _____ Occupation:_____

Spouse's Name _____Spouse's Employer_____

Number of children and Ages: _____

Name & Number of Emergency Contact: _____Relationship: _____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primarily:_____
Secondarily: _____ Third: _____ Fourth:_____

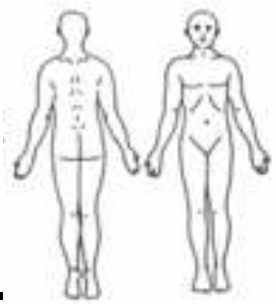
On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by c***ircling the number*****:**
Primary or chief complaint is : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Second complaints is : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Third complaint: : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Fourth complaint: : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
When did the problem(s) begin? _____ When is the problem at its worst? o AM o PM o mid-day o late PM
How long does it last? ▫ It is constant **OR** ▫ I experience it on and off during the day **OR** ▫ It comes and goes throughout the week

How did the injury happen?_____

Condition(s) ever been treated by anyone in the past? ▫No ▫ Yes **If yes,** when: _____ by whom?_____

How long were you under care: _____ What were the results?_____

Name of Previous Chiropractor: _____ ▫ **N/A**



***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:
R = **R**adiating **B** = **B**urning **D** = **D**ull **A** = Aching **N** = **N**umbness **S** = **S**harp/ **S**tabbing **T**= **T**ingling

What relieves your symptoms? _____

What makes them feel worse? _____

LIST RESTRICTED ACTIVITY: CURRENT ACTIVITY LEVEL

USUAL ACTIVITY LEVEL

_____:_____

_____:_____

_____:_____

_____:_____

Is your problem the result of ANY type of accident? o Yes, o No
Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

_____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? q No q Yes **If yes** how many times? _____ When was the last episode? _____ How did the injury happen?_____

Other forms of treatment tried: o No o Yes **If yes,** please state **what** type of treatment: _____, and who provided it: _____ **How long ago? _____**What were the results. o Favorable o Unfavorable please explain.

_____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the ***Past*, C** for ***Currently*** have and **N** for ***Never have had*:**

___ Broken Bone **___**Dislocations **___** Tumors **___**Rheumatoid Arthritis ___ Fracture **___**Disability ___Cancer
___ Heart Attack ___Osteo Arthritis ___ Diabetes **___**Cerebral Vascular **___** Other serious conditions:

LIST INJURIES →
LIST SURGERIES →
LIST CHILDHOOD DISEASES →
LIST ADULT DISEASES →

SOCIAL HISTORY

1. Smoking: ❑cigars ❑ pipe ❑ cigarettes → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
2. Alcoholic Beverage: consumption occurs → ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
3. Recreational Drug use: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
4. Hobbies -Recreational Activities- Exercise Regime: How does your present problem affect the following, See pg 2- Activities of Life

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? q No q Yes
If yes whom: q grandmother q grandfather q mother q father q sister's q brother's q son(s) q daughter(s)
Have they ever been treated for their condition? q No q Yes q I don't know
2. Any other hereditary conditions the doctor should be aware of. q No ❑Yes: _____

I hereby authorize payment to be made directly to Liberation Chiropractic & Wellness P.C., for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Liberation Chiropractic & Wellness, P.C. for any and all services I receive at this office.

_____ _____
Patient or Authorized Person's Signature **Date Completed**

_____ _____
Doctor's Signature **Date Form Reviewed**

Automobile/Personal Injury Accident or Worker's Compensation Questionnaire

Please answer all questions completely

Dear Patient: This information is considered confidential. We need this information because we care enough to want
to know and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form.
Thank you.

Please explain in detail how your accident happened._____

_____

_____

What were the time and date of present injury? _____

Where did you feel pain immediately after the accident?_____

List the extent of your injuries as you know them:_____

_____

Did you require post accident hospitalization? (Yes/ No)

Check symptoms you have noticed since the accident:

_____Headaches	_____Dizziness	_____Depression	_____Fatigue
_____Light Bothers Eyes	_____Buzzing in Ears	_____Diarrhea	_____Neck Pain
_____Head Seems too Heavy	_____Memory Loss	_____Feet Cold	_____Neck Stiff
_____Pins and Needles in Arms	_____Ears Ring	_____Hands Cold	_____Fainting
_____Sleeping Problems	_____Back Pain	_____Face Flushed	_____Loss of Balance
_____Pins and Needles in Legs	_____Constipation	_____Tension	_____Nervousness
_____Numbness in Fingers	_____Loss of Smell	_____Fever	_____Irritability
_____Numbness in Toes	_____Loss of Taste	_____Chest Pain	_____Cold Sweats
_____Shortness of Breath	_____Stomach Upset		

Symptoms other than above:_____

_____

Where were you taken after the accident?_____

Hospitalized? Yes/ No If yes, admitted? _____ How long? _____

Name of Hospital:_____

Name of Doctors:_____

What treatment was given?_____

Was any other doctor consulted after your accident? (Yes/ No)

If so, what was the doctor's name? _____ D.C., M.D., D.O., D.D.S.

What was the diagnosis?_____

What treatment was given? _____

How often did you see the doctor?_____

How long did you see the doctor? _____

Have you ever had any complaints in the involved area before? (Yes/ No)

If so, what were the complaints?_____

Before the injury were you capable of working on an equal basis with others your age? (Yes/ No)

Are your work activities restricted as a result of this accident? (Yes/ No)

Since this injury are your symptoms, Improving? Getting worse? Same?

Driver of other vehicle (if any)

Name: _____Insurance Company: _____ Policy No._____

Driver of vehicle in which you were injured (if applicable)

Name: _____Insurance Company: _____ Policy No._____

Name of your insurance adjustor: _____

You were heading North/ East/ South/ West on: _____(street or highway)

Other vehicle was heading North/ East/ South/ West on: _____ (street or highway)

Were police notified? (Yes/ No)

Were you knocked unconscious? (Yes/ No) If so, for how long?_____

You were struck from: Behind Front Left Side Right Side

You were: Driver Passenger Front seat Back Seat Using seat belts

_____ _____
Patient's Name DOB

_____ _____
Patient signature DATE

_____ _____
Doctor signature DATE REVIEWED

ACTIVITIES OF DAILY LIVING/SYMPTOMS/MEDICATIONS

Daily Activities: Effects of Current conditions On Performance

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Bending	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Concentrating	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Doing computer Work	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Gardening	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Playing Sports	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Recreation Activities	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Shoveling	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Sleeping	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Watching TV	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Carrying	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Dancing	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Dressing	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Lifting	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Pushing	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Rolling Over	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Sitting	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Standing	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Working	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Climbing	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Doing Chores	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Driving	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Performing Sexual Activity	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Reading	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Running	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Sitting to Standing	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Walking	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform

Please mark P for in the **Past, C** for **Currently** have and **N** for **Never**

___ Headache	___ Pregnant (Now)	___ Dizziness	___ Prostate Problems	___ Ulcers
___ Neck Pain	___ Frequent Colds/Flu	___ Loss of Balance	___ Impotence/Sexual Dysfun.	___ Heartburn
___ Jaw Pain, TMJ	___ Convulsions/Epilepsy	___ Fainting	___ Digestive Problems	___ Heart Problem
___ Shoulder Pain	___ Tremors	___ Double Vision	___ Colon Trouble	___ High Blood Pressure
___ Upper Back Pain	___ Chest Pain	___ Blurred Vision	___ Diarrhea/Constipation	___ Low Blood Pressure
___ Mid Back Pain	___ Pain w/Cough/Sneeze	___ Ringing in Ears	___ Menopausal Problems	___ Asthma
___ Low Back Pain	___ Foot or Knee Problems	___ Hearing Loss	___ Menstrual Problem	___ Difficulty Breathing
___ Hip Pain	___ Sinus/Drainage Problem	___ Depression	___ PMS	___ Lung Problems
___ Back Curvature	___ Swollen/Painful Joints	___ Irritable	___ Bed Wetting	___ Kidney Trouble
___ Scoliosis	___ Skin Problems	___ Mood Changes	___ Learning Disability	___ Gall Bladder Trouble
___ Numb/Tingling arms, hands, fingers		___ ADD/ADHD	___ Eating Disorder	___ Liver Trouble
___ Numb/Tingling legs, feet, toes		___ Allergies	___ Trouble Sleeping	___ Hepatitis (A,B,C)

List Prescription & Non-Prescription drugs you take:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Doctor's Signature **Date Form Reviewed**

JDD,DC 5/2011

INITIAL NERVE SYSTEM PROFILE

When was your most recent auto accident? _____What speed was the collision?_____mph

Type of impact: Front / Side / Rear Was treatment received? Please describe:_____

When was your most recent strain / stress at work?_____

Please describe the manner of the injury: _____

Was treatment received? Please describe:_____

Does your job require you remain in long term stressful postures? _____
(*i.e. all day seating, repeated lifting, long term computer use)*

Spinal traumas in the past? _____

Collision, quick burst, or repetitive motion sports: football, wrestling, basketball, baseball, soccer, tennis, golf, track and field:_____

Trauma as a child! i.e. fall on your head, impact to your head, concussion, fall onto your back or tailbone, biking accident:_____

Work around the house – lifting, bending, woke up with stiff neck, "back went out":

_____

INITIAL NUTRITIONAL PROFILE

Have you tested with high triglycerides or high cholesterol?	(Y / N) Values?_____
Have you tested with high blood pressure?	(Y / N)
Are you diabetic, been diagnosed as pre-diabetic or with metabolic syndrome?	(Y / N)
Do you eat breakfast daily from Monday to Friday?	(Y / N)
How many days per week do you skip one meal?	(0) (1) (2) (3) (4+)
How many fast food, refined foods, or pre-pared meals do you eat per week?	(0) (1-3) (4-6) (7+)
How many servings of fruit do you have on a given day?	(0-1) (2-3) (4+)
How many servings of vegetables do you have on a given day?	(0-1) (2-3) (4-5)

Do you regularly drink (1 or more per day) any of the following? (circle all that apply)

Diet Soda Coffee Juice Milk Soda Alcohol

Please list any supplements you take regularly:

_____

_____

_____

_____

_____

_____

_____

INITIAL FITNESS PROFILE

How many times per week do you exercise?

Cardiovascular: ___Hours ___Days/Wk Weight Training: ___Hours ___Days/Wk

Low Impact (Yoga, etc.) ___Hours ___Days/Wk _____: ___Hours ___Days/Wk

What is your target weight? _____lbs What is your current weight? _____lbs

How willing are you to change any of these things to reach your health goals? ***(Scale of 1-10)*** **_____**

INITIAL TOXICITY PROFILE

Are you regularly exposed to cleaning products or industrial chemicals?	(Y / N)
Have you ever noticed mold growing in your home or your place of work?	(Y / N)
Does your home, work, school, or car have damp or mildew smell?	(Y / N)
Have you received a full standard profile of vaccinations?	(Y / N)
Do you receive yearly flu shots?	(Y / N)
How many flu shots have you received? (estimate)	_____
Have any members of your family been diagnosed with fibromyalgia, chronic fatigue or multiple chemical sensitivities?	(Y / N)
Do you have symptoms of hormonal system imbalance (thyroid, reproductive, adrenal)?	(Y / N)

INITIAL STRESS PROFILE

Do you get an average of 8 hours of sleep per night?	(Y/N)
Do you average less than 7 hours of sleep per night?	(Y/N)
Do you ever take pills to go to sleep or relax?	(Y/N)
Do you often feel short on time and procrastinate on projects?	(Y / N)
Do you experience feelings of anxiety about completing tasks?	(Y / N)
Do you feel like you don't give enough time or attention to important areas in your life like family, personal growth, or a hobby?	(Y / N)
Do you rely more on your memory than a planner and action list to get things done?	(Y / N)
Do you take time to pray, meditate, or visualize on a regular basis?	(Y / N)

Doctor Signature _____ **Date Reviewed** _____

JDD, DC 5/2011

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Liberation Chiropractic & Wellness PC have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____  *Witness Initials*

Patient or Authorized person's Signature Date

REGARDING: X-rays/Imaging Studies

FEMALES ONLY → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

▫ The first day of my last menstrual cycle was on ____-____-____ Date

▫ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____  *Witness Initials*

Patient or Authorized person's Signature Date

Liberation Chiropractic & Wellness P.C. Notice of Privacy Practice

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders -**we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or up coming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:
If you wish to make a formal complaint about how we handle your health information, please call Danelle Adair at (251) 607-0040. If she is unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days . If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

Liberation Chiropractic & Wellness PC's NOTICE REGARDING YOUR RIGHT TO PRIVACY continued….

I have received a copy of Liberation Chiropractic & Wellness PC's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____	_____	_____
Patient's Name	DOB	HR#
_____	_____	
Patient signature	Date	
_____	_____	
Witness	Date	

OFFICE POLICIES

Welcome to Liberation Chiropractic & Wellness PC!

As a potential new patient, we feel it is important that you understand our office policies regarding, how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return. Once you have read "Our Office Policies", if you have any questions or any of these policies are unclear to you, and you would like further explanation before submitting your ***Application for Care*****,** please let our front desk know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone's best interests to provide potential new patients as much information as possible about how the doctors at this office practice chiropractic so that an informed decision can be made as to whether they wish to become a patient.

Over time, individuals who are accepted, as patients at this office, gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open bay area, patients have a unique opportunity to observe firsthand the positive results that are achieved and the benefits derived from being under chiropractic care. This knowledge and awareness reaps a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about.

□ **PATIENT PRIVACY** - Since the majority of patient care takes place in an open bay area it is important to understand that any conversations you have with the doctor can be overheard by other patients. In order to maintain patient privacy it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter you wish to discuss please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.

□ **YOUR CARE** - When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at Liberation Chiropractic & Wellness PC is rendered primarily to minimize and reduce subluxations, which are a major interference to the expression of the body's innate wisdom. The doctors use 1) Dr. Bucknell Corrective Technique OR 2) a myriad of techniques to accomplish this goal, including but not limited to CLEAR, Pettibon, Arthrostim, Diversified, SOT, ART, and CBP. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through two distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving you overall health.

□ **FIRST THINGS FIRST**- Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do in addition to being adjusted to maintain their health for a lifetime.

□ **PATIENT'S REPORT OF FINDINGS** – To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your first adjustment, you will be scheduled for a 'Doctors Report of Findings'. The information you receive at this appointment will be both informative and clinically relevant to your case, therefore attendance is required for individuals who wish to become new patients of this practice. Because the results of your x-rays and all examinations as well as the doctors' recommendations for care, will be discussed at that time, we strongly urge new patients to invite their spouse or significant other to attend. We know from experience that when a patient's family understands the goals and objectives of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options.

Patient initials: _____-retaining pages 1 of 2

I hereby acknowledge receiving a copy of the practices 'Office Policies' a two page document, the first page of which I have read and retained. This second page is recognized by me as the signature page and will be retained by the practice as evidence of my receiving and understanding this 'Notice'. I further acknowledge that any concerns regarding these 'Policies 'as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.

_____ _____ __ _____
Patient's Name DOB HR#

_____ _____
Patient signature Date

_____ _____
Witness Date

FINANCIAL AGREEMENT OF UNDERSTANDING

I would like to become a patient of Liberation Chiropractic & Wellness and participate in the Billing Simplification program offered by this practice to facilitate effortless payment for a certain portion of the cost of services and procedures I have consented to receive over the course of my treatment.

☐ INSURANCE PATIENTS

I have been made aware that most insurance plans impose either a visit or dollar limit and/or restrict chiropractic management approaches by covering only a limited number of treatment types and/or techniques, some of which may be used to treat my condition(s) throughout the clinical course of my care. Further, it has been made clear to me that these limitations are not a consideration in formulating care plans, and that the doctor's recommendations are based solely on achieving my personal goals. With this understood and the realization that full insurance reimbursement is unlikely, I agree to follow the doctor's recommendations for care irrespective of my health plan coverage.

In as much as the doctor has discussed the terms of this 'Agreement of Understanding' and I have conveyed my complete understanding of all payment options available to me, I prefer the office to bill my insurance company and await direct provider reimbursement for all covered services. For this consideration, I will provide any and all assistance, including assigning my benefits, in order to ensure proper reimbursement is made directly to Dr. Michael Bucknell as expeditiously as possible. I further understand that charges for all services have been reviewed with me in advance and those that my insurance does not cover are my responsibility. I further waive any requirement moving forward to sign a "Non-Covered Services Statement" every visit.

☐ CASH PATIENTS

I would like to participate in the payment simplification program offered at this office. Payment options will be provided along with care plan recommendations.

If for any reason I decide to discontinue my care plan, any unused amount I have prepaid will be refunded to me within 30 days of the practice receiving a written statement from me explaining the reasons for my decision.

I understand that my care plan has been designed to stabilize and correct the spine in order to reduce pressure from the nervous system. This is done per the exam and x-ray findings and our clinical experience with the goal of improving overall structure and function. In addition, I understand that my schedule for care may be increased or decreased by the doctor at any time in order to accomplish this goal. It is further understood that if there are any additional costs associated with a change in my care plan, they will be discussed with me prior to my receiving any additional services.

It has been explained to me and I acknowledge that the care plan I wish to participate in imposes two 'situational restrictions' which could cause my care to be suspended or terminated should either one occur. Both have been explained to me and I understand and agree to immediately notify this practice should the following circumstances arise:

In the event I sustain a new injury or have an accident, I realize that I may experience new symptoms and/or a new problem may arise which could impede recovery from my current condition. In such an instance, I recognize that it is important to evaluate any new symptoms to determine how they may affect my current and future health status and assess whether there is a need to modify my current care plan. Once my new symptoms and condition are diagnosed and/or resolved, my care plan will resume.

In the event I decide to interrupt any payment due this office, either because I wish to discontinue my care or for any other reason, I may not resume care without an additional evaluation from my doctor. If I am making monthly payments at that time, it is possible that I will owe money since more services are being rendered in the beginning of my care than the monthly fee covers.

_____ _____

(Patient's Signature) (Date)

_____ _____

(Witness) (Date)