

**Please list all medication that you take, the dosage, and if it is taken on regular basis:**

Medication Name	Reason Used	Dosage	Regular Basis?	
_____	_____	_____	Y	N
_____	_____	_____	Y	N
_____	_____	_____	Y	N
_____	_____	_____	Y	N
_____	_____	_____	Y	N
_____	_____	_____	Y	N

Do you feel the medication is helping you? \_\_\_\_\_

**Please list all nutrition supplements that you take and if it is on regular basis:**

Supplement Name	Regular Basis?		Supplement Name	Regular Basis?	
_____	Y	N	_____	Y	N
_____	Y	N	_____	Y	N
_____	Y	N	_____	Y	N
_____	Y	N	_____	Y	N
_____	Y	N	_____	Y	N

Do you feel that the medication is helping you? \_\_\_\_\_

**AUTHORIZATION AND RELEASE:** I, the undersigned, certify that I am financially responsible for all charges, whether or not my insurance company pays them. I hereby authorize **A&M CHIROPRACTIC, LLC** to release any and all information necessary to secure the payment of benefits. I also accept the responsibility for any fees associated with providing such information to my insurance company. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

We want to thank you for choosing us as your chiropractic health provider. In order to provide you and other patients with the most optimal care, we request that you follow our guidelines regarding our broken and / or cancelled appointments. Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hours notice in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients.

Our office does reserve the right to charge for cancellation with less than 24 hours notice and broken appointment. We also reserve the right to retain an active credit card on hand for securing reserved appointments. Thank you for your consideration of our policies and for the opportunity to be your chiropractic office of choice.

The patient understands and agrees to allow **A&M CHIROPRACTIC, LLC** to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your right concerning those records. If you would like to have a more detailed account of a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPPA notice that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform us.

Patient / Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_