Back in the Game

SPORTS MEDICINE, LLC

Welcome! New federal laws require photocopies of ID and insurance card please bring these cards to your 1st visit

First Name _____ Primary (ex. 222222222) _____

Last Name _____ Birth Date _____

Address _____

City _____ State _____ Zip Code _____ Sex: ◯ Male ◯ Female

Marital Status: ◯ Single ◯ Married ◯ Other SSN (ex. 999999999) _____

Employer _____

Optional Information

In order to serve you better we will email patient educational links and community updates

email _____

Emergency contact

Name: _____ Phone number _____

How did you hear about us? _____

To our Patients

*I hereby authorize Back In the Game and independent providers to furnish the insured's insurance company all information which said insurance company may request concerning my presenting illness or injury. I hereby assign to said provider all money to which I am entitled for health expenses relative to the services performed form time to time. I understand I am financially responsible for any and all charges.

**I acknowledge that I have received, reviewed, understandand agree to the the Notice of Privacy Practices of Back in the Game LLC, which describes the practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

***Consent to treat: Chiropractic examination and therapeutic procedures (including spinal adjustment, ultrasound, heat application, electrotherapy, graston, and manual manual muscle therapy) are considered safe and effective methods of care. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. Side effects include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare including fractures and damage to the arteries.

I have read and understand the above statements regarding financial responsiblity, privacy practices, and treatment side-effects.

Signature: _____

Date: _____

Email | Print Form