WELCOME TO ALIGNED 4 LIFE

Our Goals:

1. Determine the cause of your pain.
2. Reduce your pain as soon as possible
3. Reduce the long term effects of your injury.
4. To document your progress
5. Refer you to the proper specialist or diagnostic test when needed.

Communication is very important, so please feel free to ask questions. Aligned 4 Life has been in practice for For several years and can answer most questions you may have. Please ask questions!

It is very important that vou follow all of the doctor's recommendations, this will allow for optimal healing. Home activities, nutrition, making your therapy appointments and avoidance of relapses are important for complete healing to occur. Remember healing takes time, but the sooner we get you out of pain the better.

Patients are typically seen 3 times a week for 4-6 weeks until the pain is 50% improved. At the end of the 4th week your condition will be re-evaluated. Once the pain is relieved, we will work to strengthen the area to ensure long term success.

Office hours: Monday & Wednesday 9-9, Thursday 9-6, Friday 9-1

PATIENT INFORMATION

Date of Birth ______________________ Age __________ Social Security # ______________________

Last ______________________ First ______________________ Middle Initial ______________

Address ______________________________ City ______________________ ST ________ Zip ________

Phone (H) ______________ (W)______________ (C)______________ Email________________

CONSENT FOR TREATMENT

I, the undersigned, a patient in this office hereby authorize AlignedLife and whomever they may designate as assistant(s) to administer treatment as is necessary. I also certify that no guarantee or assurance has been made as to the results that may be obtained. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from my insurance company and that pay amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account.

Patient's Signature ________________________________ Date ____________________

CONSENT FOR TREATMENT OF MINOR

I, the undersigned, hereby authorize AlignedLife and whomever they may designate as assistant(s) to administer chiropractic care as is necessary to ________________________________ .

Patient's Signature ________________________________ Date ____________________