Valley Chiropractic

Name:_____**Resident Phone**:_____
Occupation:_____**Office Phone**:_____
Address:_____**City**:_____
Postal Code:_____
Birthdate:_____**CareCard#**_____
Email Address:_____

Is this a **WCB, ICBC DVA** or **RCMP** claim?_____
Please indicate who recommended you to this office._____
Have you received any chiropractic care in the past?_____
Please indicate your most recent care_____
Please indicate current condition_____
_____
What caused this condition?_____
How long has this condition been present?_____
What activities cause aggravation?_____
What relieves the problem?_____
Is this condition: getting worse□remaining constant □coming & going □other □
(describe)_____
Have you received other forms of treatment for your condition (medical, physiotherapy, etc.)?(describe)_____
_____
Have you been treated by a physician in the past year? (describe)_____
_____
Please list any medications you are taking_____
_____
Please list past surgeries or fractures (beginning with the most recent)._____
_____
Have you had any serious illness?_____
_____

GENERAL SYMPTOM SURVEY

□Heart Related Disorders
□Bronchial Related Conditions
□Visual Disturbances
□Hearing Disorders
□Digestive Disorders
□Menstrual Difficulties
□Chronic Joint Discomfort
□Nervous Disorders (sleep disorders, depression)
□Arm or Leg Numbness (tingling)
□**FAMILY** history of TB, Diabetes, Heart Condition, Cancer

ASSIGNMENT OF MEDICAL SERVICES PLAN BENEFITS

If subsidized by B.C. Medical Plan, I request my benefits to be paid to VALLEY CHIROPRACTIC for chiropractic services rendered according to the Medical and Health Care Services Act.

FEE SCHEDULE

All costs for treatment and x-rays are the responsibility of the patient. Services rendered in this office are the responsibility of the patient should medical services plan or other third party fail to pay all or part of the amount due.

Consultation/ Examination- **$40.00** (with medical G1 Classification)
$17.00 (with medical V2 Classification) until maximum has been reached.
V2 classification have 10 visits divided between chiropractic, massage and physiotherapy that are partially covered by M.S.P.

Children & Students (children under the age of 17)**-$17.00** (with MSPcoverage)
$20.00 (with no MSP).

X-rays- **$75.00+**

Computerized Spinal Exam- **$30.00**

Subsequent Visits- **$40.00**(with medical G1 Classification)
$17.00(with medical V2 Classification and MSP Coverage.
$40.00(with medical V2 classification and no MSP coverage.

Private (If No Medical)**-** **Consultation- $40.00**
Subsequent visits- $40.00

Payment is due when services rendered unless patient is on a payment plan. I have read the above and understand and accept this fee schedule.

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and, if necessary, diagnostic x-rays, gait analysis assessment and bio-mechanical assessment, on me by doctors in the Valley Chiropractic office.

I have had an opportunity to discuss with the doctor of chiropractic and/or with the office clinic personnel, the nature and purpose of the chiropractic adjustments and other procedures. I understand that the results are not guaranteed.

I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited, to muscle strains and sprains, disc injuries, and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read the above consent, or have had it read to me. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and future condition(s) for which I seek treatment.

I give full permission for my child/dependent _____
to have chiropractic treatment as deemed necessary from Valley Chiropractic.

_____ _____
Patient's Name (please print) Signature of Patient (Parent/guardian)

_____ _____
Witness Date