

Ennen Chiropractic Inc.

PATIENT INFORMATION FORM

Today's Date _____

Name _____ E-mail Address _____

Address _____

City _____ ST _____ Zip Code _____

Phone Number (hm) _____ (wk) _____ (Cell) _____

Male or Female Birthdate: ___ / ___ / ___ Age _____ SS# _____ - _____ - _____

Height/Weight _____ driver's License # _____

Marital Status _____ Spouse _____ #of Children _____

Occupation _____

Employer and Work Address _____

Emergency Contact (Name and Phone Number) _____

Primary Physician (Name, Address and Phone Number) _____

Date of Last Visit _____

Referred By _____

WHAT ARE YOUR HEALTH PROBLEMS?

**ARE YOU SEEKING CARE FOR A CONDITION RELATED TO WORKER'S COMP
OR PERSONAL INJURY? YES /NO**

WHAT ADDITIONAL INFORMATION WOULD YOU LIKE DR. ENNEN TO KNOW?

Ennen Chiropractic Inc.
13420 Newport Ave., Ste. K
Tustin CA 92780

714-669- 3105

FAX 714-669-3108

Fees and Appointments

Our usual and customary fee schedule:

New Patient Initial Visit and Exam (approx. 1 hour)	\$175.00	
New Patient Brief exam		\$85.00
Regular Office Visit (15 minutes)	\$65.00	
Extended Visit(½ hour)	\$85.00	
Ionic Cleansing Therapy	\$45.00	
House Calls (per hour including travel) \$250 (plus long distance fees)		
Phone consult (ultra brief 5 mins)	\$25.00	
Phone consult (routine 10 mins)	\$45.00	
Phone consult (extended blood work consult 15-20 mins)	\$65.00	

*nutritional supplements, laboratory fees, ortho/neuro supplies, imaging studies, books, etc. are charged separately.

1) PAYMENT IS REQUIRED AT THE TIME SERVICES ARE PROVIDED: We accept cash, checks, care credit, financing plans, and credit cards. (Visa, MasterCard ONLY). Any other payment arrangements should be cleared with Dr. Ennen prior to your appointment. If you are experiencing financial hardship and require special arrangements, please notify our office manager prior to receiving care. Payment plans and a sliding scale are available for students and those on a limited income.

2) THIS OFFICE MAINTAINS A 24-HOUR CANCELLATION POLICY: We will do our best to honor your time by staying on schedule. Please help us by arriving on time for your appointments. If you arrive late, the time missed is deducted from your appointment. If you need to reschedule an appointment, we ask that you give us at least 48 hours notice. If you do not notify us at least 24 hours in advance, you are responsible for paying for the time reserved for you in full (we make allowances in case of true emergencies). We exist to serve you. When you need us, please call our office immediately and we will do our best to make room for you as soon as possible.

3) I release Ennen Chiropractic Inc. and Dr. John Ennen from HIPAA compliance and give him permission to share information about me with his staff and others whenever he feels it is necessary and appropriate to support my care, to work with others who may be involved with my care, to increase my likelihood of being reimbursed, to protect his interests, for office purposes, or when required to do so by law.

4) Health insurance: as a courtesy to our patients we will bill your insurance for you. However, you will be responsible for any and all unpaid balances that your insurance does not cover, refuses to pay or deems medically unnecessary.

I fully understand and agree to the above policies and fees & I request care from Dr Ennen and his staff.

Patient Signature

Date

If the patient is a minor (under 18 years of age) or unable to give their own consent, permission for treatment must be granted by their authorized parent, custodian or legal guardian.

I, _____ the parent/legal guardian of _____,
Age _____ do hereby authorize and request Dr. John Ennen, D.C. to provide care for my child/ legal trustee and I agree to be financially responsible for such care.

Parent/ legal guardian signature

Date

Informed Consent for Chiropractic Treatment and Care

I hereby request and consent to chiropractic adjustments and other procedures including, but not limited to, physiotherapy, diagnostic imaging, laboratory analysis, structural, biochemical, and functional neurological assessments and therapies, etc. by Dr. John Ennen and/or the Associate Doctors or Interns affiliated with him.

I understand that there are risks to chiropractic adjustments including, but not limited to, sprains, strains, fractures, disc injuries, strokes, and dislocations. I do not expect the doctor to be able to anticipate and explain all possible risks and complications. I wish to rely on the doctor's judgment during the course of my care and request that he does what he feels at the time is in my best interest, based on the facts then known.

I have read or have had the above consent read to me. By my signature, I agree to the above and request treatment from Dr John Ennen, his Associate Doctor, or Intern. I intend this consent form to cover any care which I receive in or through Dr. Ennen's office now and in the future.

Patient's Name

Date of birth

Patient's or Patient's Guardian's Signature

Today's Date

Guardian's Name if Patient is under 18 years old