Dr. David Geary
Dr. Jacob Zika

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Julie Obrien, NP

INFORMED CONSENT AND PATIENT INFORMATION FOR ELECTRODERMAL SCREENING

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (Home) _____ (Cell) _____

Date of Birth: _____ Soc. Sec. Number: _____
Who referred you to our clinic? _____
Are you currently under Chiropractic care? _____
If so, when was your last visit? _____

Informed Consent

I understand that the analysis I am about to receive is for wellness purposes ONLY, and that it is not for the purpose of diagnosing or treating cancer or any other disease or pathology.

I understand that the purpose of this analysis is to determine any meridian imbalances in my body. Any program recommendations will be designed to correct those imbalances for the purpose of improving and/or maintaining my level of wellness and not for the treatment, amelioration or cure of any disease process.

This has been explained to me, I understand it, and have had the opportunity to ask questions.

Signature: _____ Date_____

AUTHORIZATION AND RELEASE: I understand and agree to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. 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. I understand there will be a fee added to overdue accounts.

Signature: _____ **Date:** _____