

## **Kelly Chiropractic Center**

When a patient seeks chiropractic care, and when a chiropractor accepts a patient for such care, it is essential that they both are seeking and working for the same goals.

Chiropractic has one goal. It is important that a patient understands this goal and the means that will be used to attain it. In this way there will be no confusion, misunderstanding, or disappointment.

Patients usually want their conditions, ailments, or symptoms treated. This is not the goal of the chiropractor. The purpose of chiropractic is to restore and maintain the integrity of the spinal cord and its nerve roots. These vital nerve pathways are housed in and protected by the bones of the spine. Tiny misalignments of the bones of the spine, which interfere with the function of the nerve pathways, are called subluxations. They come from many causes and prevent the body from working properly.

By means of a chiropractic adjustment, subluxations are corrected, restoring normal nerve function. The goal of chiropractic is to correct these subluxations so that every part of the body may have a proper nerve supply at all times. This allows the innate healing ability of the body to work at maximum efficiency.

With proper nerve supply, health improves. In some, symptoms clear up quickly, for others, the process is slower; in some it is only partial, or not at all.

Regardless of the disease, the chiropractor is not offering to heal, treat or cure it. His goal is to allow the body to do its job as best it can without nerve interferences. This goal is accomplished by the correction of the vertebral subluxation.

The chiropractor examination and adjustment are not substitutes for other types of health care, just as other types of care do not take the place of chiropractic.

I \_\_\_\_\_ have read the above, understand it fully, and undertake chiropractic care on this basis.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Kelly Chiropractic Center**

**FINANCIAL POLICY**

We no longer accept insurance assignment. It is the policy of this office to collect all fees at the time that services are rendered

Upon request we will supply you with a detailed statement on each visit you can submit to your insurance carrier. We will respond in a timely manner to any requests for information from an insurance company which may be needed to process you claims.

We strive to make available to everyone and keep our charges affordable

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

**R.J. Kelly Chiropractic Center  
3804 South Gessner  
Houston TX. 77063**

Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Email \_\_\_\_\_

Would you like to receive notifications via email? \_\_\_\_\_

Birthday \_\_\_\_\_ Age \_\_\_\_\_

Male ( ) Female ( ) Number of Children \_\_\_\_\_

Marital Status: Married ( ) Single ( ) Divorced ( ) Separated ( ) Widowed ( )

Social Security Number \_\_\_\_\_

Driver's License number \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_

Employer \_\_\_\_\_

Work Address \_\_\_\_\_

Work Phone \_\_\_\_\_ Ext \_\_\_\_\_

Type of work \_\_\_\_\_

Primary party responsible for payment \_\_\_\_\_

Payment Method: Cash ( ) Check ( ) Credit Card ( )

Would you like us to hold your credit card number on file and use it for payment each visit? If so please give us you CC number \_\_\_\_\_

Exp \_\_\_\_\_

.....  
Primary reason for today's visit? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Authorization for Care**

**I hereby authorize the Doctor to work with my condition through the use of adjustments to the spine, as he deems appropriate.  
I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I**

**suspend or terminate my care, any fees for professional services rendered me will become immediately due or payable.**

**Ownership of X-ray films**

**It is understood and agreed that the payments to the Doctor for x-rays is for examination of the x-rays only. The x-ray negatives will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient of this office.**

**Patients**

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_