

Darby Chiropractic
How our office works

Please read the following information to learn more about our practice. If you'd like to schedule a new patient appointment, please text 337-364-6543.

A first visit averages \$125.

- We will do our best to help you feel better, as quickly as possible. However we are not a quick care clinic and in our experience, Chiropractic typically works best over time.
- We take Chiropractic with the utmost seriousness, and we will evaluate your condition before any treatment is rendered. This may include ordering Xrays.
- We are primarily in-network providers with BCBS and Aetna. There are several insurance carriers that we are not in-network with. However, our fees are very reasonable from what many people tell us.
- If you have BCBS or Aetna, please text a screenshot of your card, so we can determine if your insurance policy will contribute to the cost of your care.
- We do not deal with active car accident cases, or work comp.
- We are not enrolled in traditional Medicare or Medicaid.
- There are some services that we offer that are not covered by insurance at all, but we have affordable payment plans.

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(Please print clearly)

Date: _____

First Name _____ MI _____ Last Name _____

Address _____

City/State/Zip _____

Home Phone:() _____ Cell Phone:() _____ SS# _____

Email: _____ Birth Date _____ Age _____

Sex _____ Marital Status (M) (S) Number of Children _____

Occupation _____

Employed by _____ Work Phone _____

How were you referred to our clinic _____

Have you ever had Chiropractic care before? _____ When? _____

Name of Insurance Company _____ Policy# _____

Patient Health History

Family Doctor's Name: _____

Medications: _____

Supplements: _____

How much water do you drink daily? _____

How often do you stretch and/or exercise? _____

Do you smoke? Y N Do you drink alcohol? Y N

Have you lost any work related to your signs/symptoms: _____

General Health History:

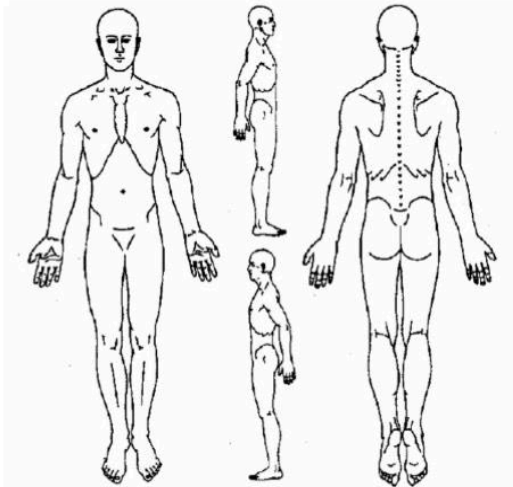
List all present and previous medical conditions, surgeries, metal implants and/or pacemaker:

Pertinent Family History: (cancer, diabetes, heart disease, stroke, arthritis):

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Patient Name: _____ DOB _____ Date: _____

Please mark your area of symptoms:



1st symptom: _____

When/how did it start? _____

What aggravates it? _____

What helps the symptom? _____

Rate on a 0-10 scale: 0 1 2 3 4 5 6 7 8 9 10

(0 is no pain, 1-3 is mild, 4-7 is moderate, 8-9 severe, 10 is very severe)

Circle all that apply for this symptom:

Sharp dull stabbing aching burning throbbing numbness stiffness radiating(where to?)

Infrequent Occasional Intermittent Frequently Constant

2nd symptom: _____

When/how did it start? _____

What aggravates it? _____

What helps the symptom? _____

Rate on a 0-10 scale: 0 1 2 3 4 5 6 7 8 9 10

(0 is no pain, 1-3 is mild, 4-7 is moderate, 8-9 severe, 10 is very severe)

Circle all that apply for this symptom:

Sharp dull stabbing aching burning throbbing numbness stiffness radiating(where to?)

Infrequent Occasional Intermittent Frequently Constant

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Informed Consent

I hereby request and consent to the performance of Chiropractic examination and treatment, including Chiropractic Adjustments and physiotherapeutics consisting of electrical muscle stimulation, ultrasound, light, heat, ice, massage, traction, and myofascial release, along with any other procedures typically performed at Darby Chiropractic. I acknowledge that these procedures have been fully explained to me by Darby Chiropractic. I acknowledge that the primary Doctors rendering specific Chiropractic treatment are Dr. David M. Darby, DC and Dr. Carol D. Darby, DC.

I understand and am informed that, as in the practice of medicine, in the practice of Chiropractic there are some risks to treatment, including but not limited to fractures, soft tissue injuries, strokes, possible burns, and dislocations. I do not expect the Doctor(s) to be able to anticipate and explain all risks and complications, and I wish to rely upon the Doctor to exercise prudent judgement during the course of the procedure which the Doctor(s) feel at the time, based upon the facts then known, is in my best interests.

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

***I also acknowledge that I have been given the opportunity to review the HIPAA notices of privacy practices employed by DARBY CHIROPRACTIC**

****I also acknowledge that as a Medicare beneficiary (if applicable), I have been given the opportunity to review an ABN, and that covered vs non-covered services, along with my options for treatment, have been explained to me fully.**

To be completed by Patient:

Patient's Name: _____

Patient's Signature: _____

Date Signed: _____

To be completed by patient's representative if patient is minor child or is unable:

Patient's Name: _____

Representative's Signature: _____

Date Signed: _____