Welcome

Because this office is a human institution to serve people, and not solely a money making organization, we hope that you will be granted peace and rest while you are under our roof.

May this room and testing facility be your "second" home. May those you love be near you in your thoughts and dreams. Even though we may get to know you well, we hope that you will be comfortable and happy as if you were in your own home.

May the problem that brought you our way be vanquished. May your testing be successful and allow accurate diagnosis and effective treatment. When you leave, may your journey be safe.

Dotto Family Chiropractic

Welcome to Dotto Family Chiropractic

Here's a breakdown of what to expect on your first visit:

1) Getting started video
2) Consultation
3) Examination
4) X-Rays (if ordered by the Doctor)

Video

The video gives a short background introducing you to chiropractic care, as well as a short introduction to what we do in our office.

Consultation

The consultation is your chance to speak with the doctor and tell him the symptoms that you have been experiencing and how it is affecting your health and lifestyle.

Examination

A thorough neurological and orthopedic examination will provide us valuable information regarding your condition and how we can get you back to heath.

X-Rays

-"To see is to know and to not see is to guess..." and we don't do guess work when it comes to your health. Your health and well-being matter too much to us and our reputation as the finest chiropractic office.

Dotto Family Chiropractic

CONFIDENTIAL PATIENT INFORMATION

Date: _____

Name _____ S.S. # _____ Home Phone: _____ Cell Phone _____

Address _____ City _____ Zip Code _____

E-Mail Address _____

Age _____ Birth Date _____ Marital Status: M S W D How many children? _____

Occupation _____ Employer _____

Address _____ Office Phone _____

Insured's name if patient is a dependent _____ Insured's D.O.B. _____

Name of Insurance Company _____ Address _____

Name of Wife or Husband _____ Occupation _____

Employer _____ Address _____

Patient's nearest relative _____ Address _____ Phone _____

Referred by: _____

Is condition due to injury or sickness arising out of patient's employment? _____

Date symptoms appeared or accident happened: _____

Patient ever had similar condition: Yes _____ No _____ If yes when and describe _____

Have you lost any days from work? _____

Date of last physical examination: _____ Female: Are you pregnant _____ Due Date: _____

What operations have you had? _____

Serious illnesses? _____ Fractured bones: _____

Have you ever been under Chiropractic Care? Yes ❑ No ❑ Doctor's Name _____

Have You Ever Suffered From:

- ❑ Allergy
- ❑ Dizziness
- ❑ Fatigue
- ❑ Headache
- ❑ Loss of sleep
- ❑ Ulcers
- ❑ Nervousness/Depression
- ❑ Numbness
- ❑ Excessive menstrual flow
- ❑ Bursitis
- ❑ Foot trouble
- ❑ Low back pain
- ❑ Neck pain or stiffness

Tingling or numbness in:

- ❑ Shoulders ❑ Hips
- ❑ Arms ❑ Legs
- ❑ Elbows ❑ Knees

- ❑ Poor Posture
- ❑ Sciatica
- ❑ Spinal curvatures
- ❑ Swollen joints
- ❑ Colon trouble
- ❑ Diarrhea
- ❑ Difficult digestion
- ❑ Hemorrhoids
- ❑ Nausea
- ❑ Asthma
- ❑ Colds
- ❑ Deafness
- ❑ Ear noises
- ❑ Enlarged Thyroid
- ❑ Eye pain
- ❑ Failing vision
- ❑ Venereal Disease

- ❑ Tuberculosis
- ❑ Bruise easily
- ❑ Hay fever
- ❑ Nosebleeds
- ❑ Sinus infection
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Pain over heart
- ❑ Poor circulation
- ❑ Rapid heart beat
- ❑ Slow heart beat
- ❑ Anemia
- ❑ Stroke
- ❑ Chest pain
- ❑ Difficult breathing
- ❑ Pleurisy
- ❑ Cancer

- ❑ Itching
- ❑ Varicose veins
- ❑ Bed-wetting
- ❑ Frequent urination
- ❑ Kidney infection/stone
- ❑ Prostate trouble
- ❑ Cramps or backache
- ❑ Arthritis
- ❑ Hot flashes
- ❑ Irregular cycle
- ❑ Lumps in breast
- ❑ Alcoholism
- ❑ Diabetes
- ❑ Polio
- ❑ Spitting
- ❑ Swelling of ankles

HABITS:

	Heavy	Moderate	Light	None
Alcohol	____	____	____	____
Coffee	____	____	____	____
Tobacco	____	____	____	____
Drugs	____	____	____	____
Exercise	____	____	____	____
Sleep	____	____	____	____
Appetite	____	____	____	____

Do you:

Now take Vitamins or minerals? Yes _____ No _____

Think you may need vitamins or minerals? Yes _____ No _____

Are you wearing: Heel lifts _____ Sole lifts ____
Inner soles _____ Arch supports ____

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Dotto Family Chiropractic

PLEASE PRINT

What brings you into our office today? _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? Yes _____ No _____ Constant _____ Comes and goes _____

Is this condition interfering with your: Work _____ Sleep _____ Daily Routine _____ Other _____

_____

How long has it been since you really felt good? _____

Other doctors seen for this condition: _____

Have you been treated for any health conditions by a physician in the last year? Yes _____ No _____

Describe _____

What medications or drugs are you taking? _____

Family doctor's name _____ Address _____

Send a report? ( ) Yes ( ) No

PAYMENT IS EXPECTED AT TIME OF VISIT!

Name of person responsible for payment _____

Are you insured? Yes _____ No _____ Company _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I will be paying today by: Cash ❑ Check ❑ Credit Card ❑

Card Name/#: _____ Exp. Date _____

Patient's Signature _____ Date _____

Guardian or Spouse's Signature Authorizing Care _____ Date _____

Information Taken by: _____

_____

_____

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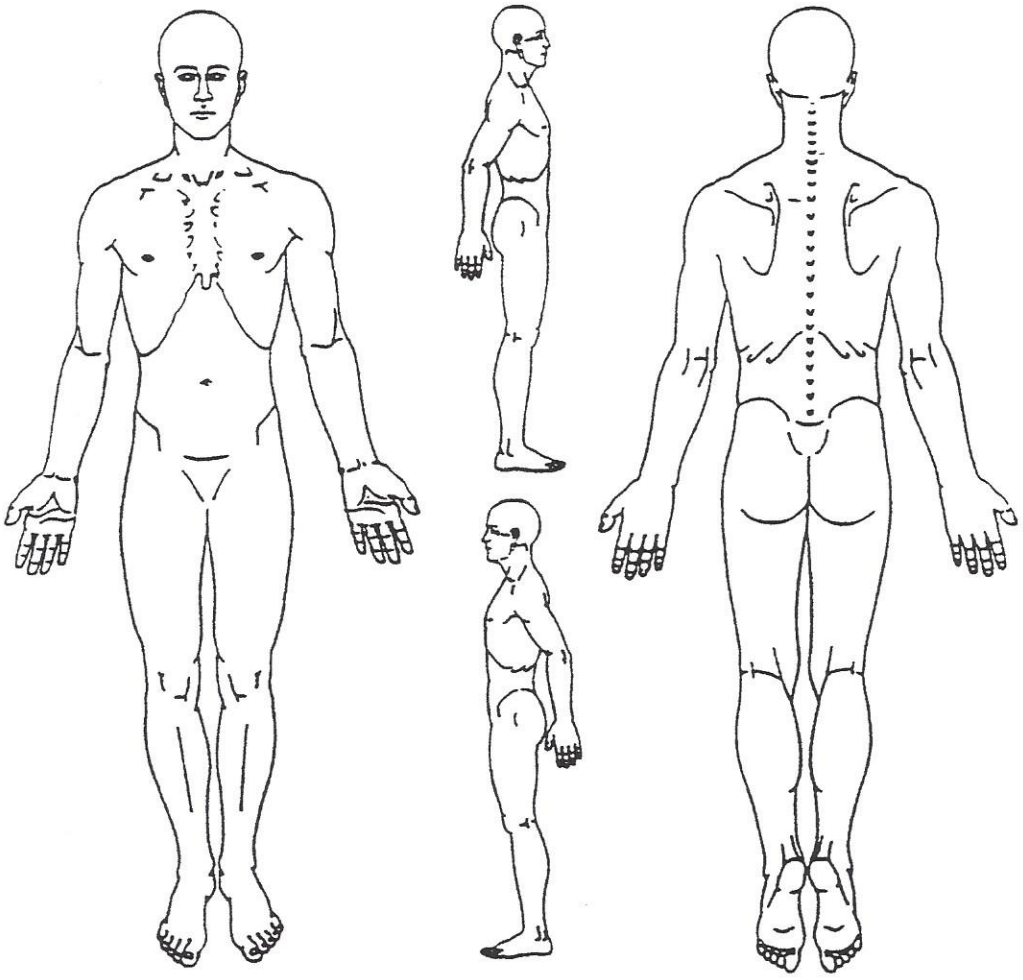
Name _____ Date _____

Mark the areas on the diagram where you feel the following sensations:

A = Aches B = Burning N = Numbness

P= Pins & Needles S= Stabbing O= Other



Indicate the severity of your symptoms by marking and "X" on the line below:

How bad are your symptoms now? _____

None Most Severe

How bad have they been in the past? _____

None Most Severe

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Headache Disability Index

Name _____ Date_____

Instructions: Please CIRCLE the correct response

1. I have headaches: [1] 1 per month [2] 2 or more than 1 but less than 4 per month [3] 3 or more per week
2. My headache is: [1] mild [2] moderate [3] severe

Instructions: PLEASE READ CAREFULLY. The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off "YES", "SOMETIMES", or "NO" to each item. Answer each item as it pertains to your headaches only.

	YES	SOMETIMES	NO
1. Because of my headaches I feel handicapped.			
2. Because of my headaches I feel restricted in performing my routine daily activities.			
3. No one understands the effect of my headaches on my life.			
4. I restrict my recreational activities (e.g. sports) because of my headaches.			
5. My headaches make me angry.			
6. Sometimes I feel that I am going to lose control because of my headaches.			
7. Because of my headaches I am less likely to socialize.			
8. My spouse (significant other), or family and friends have no idea what I am going through because of my headaches.			
9. My headaches are so bad that I feel I am going to go insane.			
10. My outlook on the world is affected by my headaches.			
11. I am afraid to go outside when I feel that a headache is starting.			
12. I feel desperate because of my headaches.			
13. I am concerned that I am paying penalties at work or home because of my headaches.			
14. My headaches place stress on my relationships with family or friends.			
15. I avoid being around people when I have a headache.			
16. I believe my headaches are making it difficult for me to achieve my goals in life.			
17. I am unable to think clearly because of my headaches.			
18. I get tense (e.g. muscle tension) because of my headaches.			
19. I do not enjoy social gatherings because of my headaches.			
20. I feel irritable because of my headaches.			
21. I avoid traveling because of my headaches.			
22. My headaches make me feel confused.			
23. My headaches make me feel frustrated.			
24. I find it difficult to read because of my headaches.			
25. I find it difficult to focus my attention away from my headaches and on other things.			

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Neck Disability Index

Name _____ Date _____

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage your everyday life. **Please answer every section and mark only ONE box** that applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box that MOST CLOSELY describes your problem.**

Section 1- Pain Intensity
- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Section 2- Personal Care (Washing, Dressing, etc.)
- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my person care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed; I wash with difficulty and stay in bed.

Section 3- Lifting
- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights, but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4- Reading
- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want to with moderate pain in my neck.
- ☐ I cannot read as much as I want because of moderate pain in my neck.
- ☐ I cannot read as much as I want because of severe pain in my neck.
- ☐ I cannot read at all.

Section 5- Headaches
- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have moderate headaches which come frequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

Comments _____
_____
_____
_____

Section 6- Concentration
- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

Section 7- Work
- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I cannot do any work at all.

Section 8- Driving
- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I cannot drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive at all because of severe pain in my neck.
- ☐ I cannot drive my car at all.

Section 9- Sleeping
- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hour sleepless).
- ☐ My sleep is mildly disturbed (1-2 hours sleepless).
- ☐ My sleep is moderately disturbed (2-3 hours sleepless).
- ☐ My sleep is greatly disturbed (3-5 hours sleepless).
- ☐ My sleep is completely disturbed (5-7 hours).

Section 10- Recreation
- ☐ I am able to engage in all of my recreational activities with no neck pain at all.
- ☐ I am able to engage in all of my recreational activities with some pain in my neck.
- ☐ I am able to engage in most, but not all of my recreational activities because of pain in my neck.
- ☐ I am able to engage in a few of my recreational activities because of pain in my neck.
- ☐ I can hardly do any recreational activities because of pain in my neck.
- ☐ I cannot do any recreational activities at all.

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Carpal Tunnel Disability Index

Name _____ Date_____

This questionnaire has been designed to give the doctor information as to how your hand/wrist pain has affected your ability to manage your everyday life. **Please answer every section and mark only ONE box** that applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box that MOST CLOSELY describes your problem.**

Section 1
How severe is the hand or wrist pain that you have at night?
- ☐ I do not have hand or wrist pain
- ☐ Mild pain
- ☐ Moderate pain
- ☐ Severe pain
- ☐ Very severe pain

Section 2
How often did hand or wrist pain wake you up during a typical night in the past two weeks?
- ☐ Never
- ☐ Once
- ☐ Two or three time
- ☐ Four or five times
- ☐ More than five times

Section 3
Do you typically have pain in your hand or wrist during the day?
- ☐ Never
- ☐ Mild
- ☐ Moderate
- ☐ Severe
- ☐ Very severe

Section 4
How often do you have hand or wrist pain during the daytime?
- ☐ Never
- ☐ One or two times per day
- ☐ Three to five times per day
- ☐ More than five times per day
- ☐ The pain is constant

Section 5
How long, on average, does an episode of pain last during the daytime?
- ☐ I never get pain during the day
- ☐ Less than 10 minutes per day
- ☐ 10 to 60 minutes per day
- ☐ More than 60 minutes per day
- ☐ The pain is constant

Comments _____
_____
_____
_____

Section 6
Do you have numbness (loss of sensation) in your hand?
- ☐ No
- ☐ I have mild numbness
- ☐ I have moderate numbness
- ☐ I have severe numbness
- ☐ I have very severe numbness

Section 7
Do you have weakness in your hand or wrist?
- ☐ I have no weakness
- ☐ I have mild weakness
- ☐ I have moderate weakness
- ☐ I have severe weakness
- ☐ I have very severe weakness

Section 8
Do you have tingling sensations in your hand?
- ☐ I have no tingling
- ☐ I have mild tingling
- ☐ I have moderate tingling
- ☐ I have severe tingling
- ☐ I have very severe tingling

Section 9
How severe is the numbness (loss of sensation) or tingling at night?
- ☐ I have no numbness or tingling at night
- ☐ I have mild numbness or tingling at night
- ☐ I have moderate numbness or tingling at night
- ☐ I have severe numbness or tingling at night
- ☐ I have very severe numbness or tingling at night

Section 10
How often did hand numbness or tingling wake you during a typical night in the last two weeks?
- ☐ Never
- ☐ Once
- ☐ Two or three time
- ☐ Four or five times
- ☐ More than five times

Section 11
Do you have difficulty with the grasping and use of small objects such as keys or pens?
- ☐ I have no difficulty
- ☐ I have mild difficulty
- ☐ I have moderate difficulty
- ☐ I have severe difficulty
- ☐ I have very severe difficulty

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Low Back Disability Index

Name _____ Date_____

This questionnaire has been designed to give the doctor information as to how your low back pain has affected your ability to manage your everyday life. **Please answer every section and mark only ONE box** that applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box that MOST CLOSELY describes your problem.**

Section 1- Pain Intensity

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is severe.
- ☐ The pain is severe and does not vary much.

Section 2- Personal Care (Washing, Dressing, etc.)

- ☐ I would not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increase the pain, but I manage not to change my way of doing it.
- ☐ Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain, I am unable to do some washing and dressing without help.
- ☐ Because of the pain, I am unable to do any washing or dressing without help.

Section 3- Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights, but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights at the most.

Section 4- Walking

- ☐ I have no pain walking.
- ☐ I have some pain walking but it does not increase with distance.
- ☐ I cannot walk more than 1 mile without increasing pain.
- ☐ I cannot walk more than ½ mile without increasing pain.
- ☐ I cannot walk more than ¼ mile without increasing pain.
- ☐ I cannot walk at all without increasing pain

Section 5- Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than ½ hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain immediately.

Comments _____
_____
_____
_____

Section 6- Standing

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain while standing, but it does not increase with time.
- ☐ I cannot stand for longer than one hour without increasing pain.
- ☐ I cannot stand for longer than ½ hour without increasing pain.
- ☐ I can't stand for more than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases pain right away.

Section 7- Sleeping

- ☐ I get no pain in bed.
- ☐ I get pain in bed, but it does not prevent me from sleeping well.
- ☐ Because of pain , my normal night's sleep is reduced by less than one-quarter.
- ☐ Because of pain, my normal night's sleep is reduced by less than one-half.
- ☐ Because of pain, my normal night's sleep is reduced by less than three-quarters.
- ☐ Pain prevents me from sleeping at all.

Section 8-Socail Life

- ☐ My social life is normal and gives me no pain.
- ☐ My social life is normal, but increases the degree of my pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- ☐ Pain has restricted my social life and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of the pain.

Section 9- Traveling

- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling, but none of my usual forms of travel make it any worse.
- ☐ I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain while traveling which compels me to seek alternative forms of travel.
- ☐ Pain restricts me to short necessary journeys under ½ hour.
- ☐ Pain prevents all forms of travel.

Section 10- Changing Degree of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates, but overall is definitely getting better.
- ☐ My pain seems to be getting better, but improvement is slow at present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

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To help expedite your insurance claims, we ask that you complete the following questions concerning the nature and onset of your symptoms.

1. Is the reason for seeing the doctor due to an automobile or work related injury?

   ( ) Yes ( ) No

2. Are you currently under care by any physician for an automobile or work injury?

   ( ) Yes ( ) No

The above information is true to the best of my knowledge. My signature below is an authorization to release this information to my insurance carrier.

_____ _____

Patient Signature Date

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INSURANCE ASSIGNMENT POLICY STATEMENT

Dear Patient:

You have selected "INSURANCE ASSIGNMENT" as the method of choice to take care of your financial obligation in this office.

It is important that you realize that in this office, we offer the option of "INSURANCE ASSIGNMENT" strictly as a courtesy to our patients, and as such, our patients must understand and agree to the following:

1. That you are considered a cash patient until you bring in completed insurance forms, and this office qualifies and accepts your coverage.
2. That you are ultimately responsible for full payment for any and all services rendered.
3. That you must pay all deductibles in full.
4. That co-insurance must be paid at the time of service.
5. That if your carrier has not paid a claim within 60 days of submission, you are responsible to take an active part in the recovery of your claim and that after 90 days you will be responsible for payment in full of any outstanding balance, and the courtesy of insurance assignment is immediately discontinued.
6. I authorize this clinic to release any information pertinent to my case to my insurance company, adjustor, and attorney involved in this case; and hereby release this clinic of any consequence thereof.
7. That, in the event you discontinue your program of care prior to doctor's consent, you are responsible for payment in full of any outstanding balance, and the courtesy of insurance assignment is immediately discontinued.

The insurance assignment policy must be followed. We ask that you sign this form as acknowledgement that our policy was explained to you, that you understand it, and that you accept full financial responsibility.

_____

Patient's Name

_____ _____

Patient/Guardian Signature Date

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DOTTO FAMILY
CHIROPRACTIC PLLC

Consent for Purpose of Treatment, Payment and Healthcare Operations

I acknowledge that Dotto Family Chiropractic PLLC "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review Dotto Family Chiropractic PLLC Notice of Privacy Practices prior to signing this document. Dotto Family Chiropractic PLLC Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Dotto Family Chiropractic PLLC is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Dotto Family Chiropractic PLLC duties with respect to my protected health information.

Dotto Family Chiropractic PLLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Print Name of Patient or Personal Representative Date

_____

Description of Personal Representative's Authority

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DOTTO FAMILY
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DISLOSURE & CONSENT FOR CHIROPRACTIC ADJUSTMENTS AND CARE

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment. The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "click", much as you have experienced when you pop your knuckles. You may feel a sense of movement.

The material risks inherent in chiropractic adjustment. As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring. Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-Ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options. Other treatment options for your condition may include:

*Self-administered, over-the-counter analgesics and rest
*Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers
*Hospitalization
*Surgery

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If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated. Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE INFORMATION ABOVE. _____
(Initial)

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Staff/Dr. Robert Dotto, & Associates, and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Date: _____ _____
Patient's Name

_____ _____
Signature Signature of Parent or Guardian (if a minor)

Date: _____ _____
Doctors' Name

_____
Signature

15365 Hubbard Street • Livonia, MI 48154 • Tel: 734-266-8444 • Fax: 734-266-8484

DOTTO FAMILY
CHIROPRACTIC PLLC

OUR APPOINTMENT POLICY

Welcome,

We are so pleased that you have chosen Dotto Family Chiropractic for your health care needs. To better serve you, we have provided specific prescheduled appointment times for your spinal adjustments.

Because we respect your busy schedule, these times are held for you so we can do our best to make sure your visits are thorough and time efficient. If in the future you cannot make your appointment, please have the courtesy to call and reschedule. Failure to do so will result in a **$30.00 missed appointment fee**.

PATIENT SIGNATURE_____

DATE_____

"WELLNESS FOR LIFE"
Dotto Family Chiropractic PLLC
Dr. Robert A. Dotto

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DOTTO FAMILY
CHIROPRACTIC PLLC

Dear Patients,

Please be courteous of our time as we are of yours, our massage therapist does not get paid for the time she is not performing a massage.

Please arrive at least ten minutes before your scheduled appointment time in order to ensure a full massage session.

If you cancel your massage without giving 24 hour notice from your scheduled massage you will be charged a $35.00 missed massage fee.

Same day cancellations will be charged $35.00

If you do not call to cancel your appointment or do not show up for your scheduled appointment you will be charged $35.00 and there will be a $35.00 deposit collected to hold on your account for any future massage appointments you have scheduled.

By signing this form you agree to these terms and understand that the $35.00 fee will be enforced.

Signature: _____

Print Name: _____

Date: _____

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DOTTO FAMILY
CHIROPRACTIC PLLC

To Our Patients,

Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible.

It is your responsibility to know your individual coverage. Failing to comply with this suggestion could result in you, the patient, being responsible for all costs incurred.

Please remember, your insurance policy is between ***YOU*** and your insurance carrier, ***NOT*** the insurance company and your doctor.

Thank you,
Dotto Family Chiropractic

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