Cain Chiropractic & Rehab, P.C.
Motor Vehicle Accident Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell: _____Work: _____ Home: _____

Insurance Information:
Policy Holder (If Different than Patient):_____
Insurance Company: _____ Policy Number: _____
Insurance Company Address: _____
Insurance Company Phone: _____
Medical Coverage ("Med Pay") Available: Yes _____ No _____ Amount: $ _____

Date of Accident: _____

Description of Accident:
Please draw a diagram below of the intersection road where your accident occurred. Your vehicle will be V1 and the other vehicles will be V2, V3, etc. Use arrows to indicate path of vehicles and to be sure to include the final positions of the vehicles after the accident.

1. In your own words, please describe how the accident occurred.
   _____
   _____
   _____
   _____
   _____

2. Whose vehicle were you in V1? _____
   Make/model/type of vehicle: _____

Vehicle 2 Type	Vehicle 3 Type	Vehicle 4 Type
□ Car □ Station Wagon	□ Car □ Station Wagon	□ Car □ Station Wagon
□ Van □ Pickup Truck	□ Van □ Pickup Truck	□ Van □ Pickup Truck
□ Large Truck □ Bus	□ Large Truck □ Bus	□ Large Truck □ Bus
Other _____	Other _____	Other _____

Automobile Accident Description

Please answer the questions below. If you do not know the answer to any of the questions, do not answer that question.

1. Your vehicle type
□ Car □ Station Wagon
□ Van □ Pickup Truck
□ Large Truck □ Bus
Other _____

2. Your position in vehicle
□ Driver □ Front Passenger
□ Left Rear Passenger
□ Right Rear Passenger
Other _____

3. What was your vehicle doing at the time of the accident?
□ Stopped at intersection □ Stopped in traffic □ Stopped at light
□ Making a right turn □ Making a left turn □ Parking
□ Proceeding along □ slowing down □ accelerating
Other_____

4. Time/Speed/Damage
Time of accident: _____
Your vehicles
Speed: _____mph
Their vehicles
Speed: _____mph
Damage to your vehicle:
□ Mild □ Moderate □Totaled

5. Details of Accident Visibility
At the time of accident:
□ Poor □ Fair □ Good
Who hit who/what?
□ You hit other vehicle
□ Other vehicle hit you
□ You hit (Object)

6. Road conditions
Road conditions at time of accident
□ Icy □ Wet □ Sandy □ Dark
□ Clean and dry
Point of impact:
□ Head-On □ Left Front □ Right Front
□ Rear □ Left Rear □ Right Rear
□ Driver's side □ Passenger side

7. Body Position, etc.
Did you see the accident coming? □Yes □ No
Were you braced for the impact? □ Yes □ No
Did you have a seat belt on? □ Yes □ No
Was your shoulder harness on? □ Yes □ No
Did driver side airbag deploy? □ Yes □ No

8. Does your vehicle have headrests? □ Yes □ No.
What was the position of your headrest at the time of the impact?
□ Even with top of head □ Even with bottom of head □ Middle of neck.
What was the direction of your head at the time of the impact?
□ Facing straight forward □ turned to the right □ Turned to the left
Did passenger side airbag deploy? □ Yes □ No
Side airbags? □ Yes □ No

9. Additional accident information
Enter any additional information here that is not covered by the above check offs.

_____
_____
_____
_____

10. During the accident:
Did your body strike inside of your vehicle?
□ Yes □ No
If yes, describe:_____
Did you lose consciousness during the injury?
□ Yes □ No
If yes, for how long? _____
Your vehicle's estimated damage?_____
Damage to their vehicle:
□ Mild □ Moderate □Totaled

11. After the accident
Check off your symptoms following the accident:

□ Headache	□ Dizziness	□Mid back pain	□ Cold hands
□ Neck pain	□ Nausea	□ Low back pain	□ Cold feet
□ Neck stiffness	□ Confusion	□ Nervousness	□ Diarrhea
□ Fainting	□ Fatigue	□ Loss of taste	□ Depression
□ Ringing in ears	□ Tension	□ Toe numbness	□ Anxious
□ Loss of smell	□ Irritability	□ Constipation	□ Chest Pain

□ Pain behind eyes □Shortness of breath □ Sleeping problems
□ Heavy Head Other: _____

Did police show up at the scene? □ Yes □ No
Other: _____

Was *an* accident report filled out? □Yes □ No
Who was determined to be at fault? □ You □ Other Driver

12. Emergency Room? □ Yes □ No
Where did you go after the accident?
□ Home □ Work □ Hospital ER □ Private Doctor
How did you get there?
□ Self □ Somebody else □ Ambulance. □ Police

X-rays done? □ Yes □ No

Body Parts X-rayed? _____
The X-rays revealed: _____
Treatments: □ Cervical Collar □ Ice Other: _____
Lab work? □ Yes □ No

What lab work? _____

Medications: _____
Follow-up instructions:_____

13. Treatment History:
Fill in other doctor(s) seen prior to your first visit to this office.
1. Dr. _____ First visit date:
Specialty: X-rays done? □ Yes □ No
Types of treatments received: _____
How many treatments received? _____
Currently treating? □ Yes □ No

Did treatments benefit you? □ Yes □ No
Last visit date:
2. Dr. _____ First visit date: _____
Types of treatments received:
How many treatments received? _____
Currently treating: □ Yes □ No
Did treatments benefit you? □ Yes □ No
Last visit date: _____

I **PRIMARY** area of concern. **(i.e. what area hurts the most?)**
Check only **ONE** body location below:

CHOOSE ONE BELOW:

□ Headaches L □ R □ B □
- □ Front of head
- □ Top of head
- □ Back of head

□ Jaw	L □	R□	B□
□ Eye	L □	R□	B□
□ Neck	L □	R□	B□
□ Upper Back	L □	R□	B□
□ Mid Back	L □	R□	B□
□ Low Back	L □	R□	B□
□ Chest	L □	R□	B□
□ Abdomen	L □	R□	B□
□ Ribs	L □	R□	B□
□ Buttocks	L □	R□	B□
□ Shoulder	L □	R□	B□
□ Upper Arm	L □	R□	B□
□ Forearm	L □	R□	B□
□ Hand	L □	R□	B□
□ Hip	L □	R□	B□
□ Leg	L □	R□	B□
□ Foot	L □	R□	B□

Other: _____
_____
_____

2. Types of pain

□ Dull □ Sharp □ Aching
□ Cutting □ Throbbing
□ Burning □ Numbness
□ Spasm □ Stinging
□ Shooting □ Pounding
□ Constricting

Other Types of pain

_____
_____
_____
_____

3. Pain Frequency
□ Up to ¼ of awake time
□ ¼ to ½ awake time
□ ½ to ¾ of awake time
□ most of the time

4. Pain Intensity (How it affects daily activities)
□ Doesn't affect
□ Somewhat affects
□ Seriously affects
□ Prevents activities

5. Does this pain radiate to other body parts?

□ Head	L □	R□	B□
□ Neck	L □	R□	B□
□ Shoulder	L □	R□	B□
□ Arm	L □	R□	B□
□ Hand	L □	R□	B□
□ Hip	L □	R□	B□
□ Knee	L □	R□	B□
□ Leg	L □	R□	B□
□ Ankle	L □	R□	B□
□ Foot	L □	R□	B□

Other: _____
_____
_____

6. Actions affecting this pain

	Brings on	Aggravates	Relieves
□ In the A.M.	□	□	□
□ In the P.M.	□	□	□
□ Bending Back	□	□	□
□ Bending Forward	□	□	□
□ Bending Right	□	□	□
□ Bending Left	□	□	□
□ Twisting Right	□	□	□
□ Twisting Left	□	□	□
□ Sneezing	□	□	□
□ Coughing	□	□	□
□ Standing	□	□	□
□ Straining	□	□	□
□ Lifting	□	□	□
□ Sitting	□	□	□

II. **SECOND** area of concern. **(i.e. what area hurts the second most?)**
Check only **ONE** body location below:

CHOOSE ONE BELOW:

□ Headaches L □ R □ B □
□ Front of head
□ Top of head
□ Back of head

□ Jaw	L □	R□	B□
□ Eye	L □	R□	B□
□ Neck	L □	R□	B□
□ Upper Back	L □	R□	B□
□ Mid Back	L □	R□	B□
□ Low Back	L □	R□	B□
□ Chest	L □	R□	B□
□ Abdomen	L □	R□	B□
□ Ribs	L □	R□	B□
□ Buttocks	L □	R□	B□
□ Shoulder	L □	R□	B□
□ Upper Arm	L □	R□	B□
□ Forearm	L □	R□	B□
□ Hand	L □	R□	B□
□ Hip	L □	R□	B□
□ Leg	L □	R□	B□
□ Foot	L □	R□	B□

Other: _____
_____
_____

2. Types of pain

□ Dull □ Sharp □ Aching
□ Cutting □ Throbbing
□ Burning □ Numbness
□ Spasm □ Stinging
□ Shooting □ Pounding
□ Constricting

3. Pain Frequency
□ Up to ¼ of awake time
□ Up to 1/4 awake time
□ ½ to ¾ of awake time
□ most all the time

4. Pain Intensity (How it affects daily activities)
□ Doesn't affect
□ Somewhat affects
□ Seriously affects
□ Prevents activities

Other Types of pain

_____
_____
_____
_____

5. Does this pain radiate to other body parts?

□ Head	L □	R□	B□
□ Neck	L □	R□	B□
□ Shoulder	L □	R□	B□
□ Arm	L □	R□	B□
□ Hand	L □	R□	B□
□ Hip	L □	R□	B□
□ Knee	L □	R□	B□
□ Ankle	L □	R□	B□
□ Leg	L □	R□	B□
□ Foot	L □	R□	B□

Other: _____
_____
_____

6. Actions affecting this pain

	Brings on	Aggravates	Relieves
□ In the A.M.	□	□	□
□ In the P.M.	□	□	□
□ Bending Back	□	□	□
□ Bending Forward	□	□	□
□ Bending Right	□	□	□
□ Bending Left	□	□	□
□ Twisting Right	□	□	□
□ Twisting Left	□	□	□
□ Sneezing	□	□	□
□ Coughing	□	□	□
□ Standing	□	□	□
□ Straining	□	□	□
□ Lifting	□	□	□
□ Sitting	□	□	□

III **THIRD** area of concern. **(i.e. what area hurts the third most?)**
Check only **ONE** body location below:

CHOOSE ONE BELOW:

□ Headaches L □ R □ B □
□ Front of head
□ Top of head
□ Back of head

□ Jaw	L □	R□	B□
□ Eye	L □	R□	B□
□ Neck	L □	R□	B□
□ Upper Back	L □	R□	B□
□ Mid Back	L □	R□	B□
□ Low Back	L □	R□	B□
□ Chest	L □	R□	B□
□ Abdomen	L □	R□	B□
□ Ribs	L □	R□	B□
□ Buttocks	L □	R□	B□
□ Shoulder	L □	R□	B□
□ Upper Arm	L □	R□	B□
□ Forearm	L □	R□	B□
□ Hand	L □	R□	B□
□ Hip	L □	R□	B□
□ Leg	L □	R□	B□
□ Foot	L □	R□	B□

Other: _____
_____
_____

2. Types of pain

□ Dull □ Sharp □ Aching
□ Cutting □ Throbbing
□ Burning □ Numbness
□ Spasm □ Stinging
□ Shooting □ Pounding
□ Constricting

3. Pain Frequency
□ Up to ¼ of awake
□ Up to ¼ awake time
□ ½ to ¾ of awake time
□ Most all the time

4. Pain Intensity (How it affects daily activities)
□ Doesn't affect
□ Somewhat affects
□ Seriously affects
□ Prevents activities

Other Types of pain

_____
_____
_____
_____

5. Does this pain radiate to other body parts?

□ Head	L □	R□	B□
□ Neck	L □	R□	B□
□ Shoulder	L □	R□	B□
□ Arm	L □	R□	B□
□ Hand	L □	R□	B□
□ Hip	L □	R□	B□
□ Knee	L □	R□	B□
□ Leg	L □	R□	B□
□ Ankle	L □	R□	B□
□ Foot	L □	R□	B□

Other:_____
_____
_____

6. Actions affecting this pain

	Brings on	Aggravates	Relieves
□ In the A.M.	□	□	□
□ In the P.M.	□	□	□
□ Bending Back	□	□	□
□ Bending Forward	□	□	□
□ Bending Right	□	□	□
□ Bending Left	□	□	□
□ Twisting Right	□	□	□
□ Twisting Left	□	□	□
□ Sneezing	□	□	□
□ Coughing	□	□	□
□ Standing	□	□	□
□ Straining	□	□	□
□ Lifting	□	□	□
□ Sitting	□	□	□

IV Other areas of concern: _____
_____
_____
_____

Activities of Daily Living Assessment

Rate your current difficulties, resulting from your accident/illness, with regard to the various activities listed below. Use the following 1 to 5 scale and WRITE IN THE APPROPRIATE NUMBER that most closely describes *your* current degree of difficulty:

1 = "I can do it without any difficulty," **2 = "I** can do it without much difficulty, despite some pain," **3 - "I** manage to do it by myself, despite marked pain," **4 = "I** manage to do it, despite the pain, but only if **I** have help," **5 = "I** cannot do it all, because of the pain."
Only fill in areas affected.

Difficulties with Self Care and Personal Hygiene Activities

___Showering ___ Combing hair ___ Drying hair ___ Brushing teeth ___ Going to toilet ___ Washing hair
___ Washing face ___ Putting on shoes ___ Tying shoes ___ Putting on shirt___ Putting on pants
___ Preparing meals ___ Cleaning dishes ___ Eating ___ Taking out trash ___ Making bed ___ Doing laundry
___ Other: _____

Difficulties with Physical Activities

___Standing ___Walking ___Kneeling ___Sitting ___ Stooping ___Reaching ___ Reclining
___Squatting ___ Bending ___ Bending back forward ___Standing for long period's
___Sitting for long periods ___Twisting left ___Twisting right
___ Leaning back ___ Leaning left ___ Leaning forward ___ Leaning right
___Walking for long periods ___Kneeling for long periods ___ Pushing things while seated
___ Pushing things while standing ___ Pulling things while seated ___ Pulling things while standing
___ Exercising upper body ___ Exercising lower body ___ Exercising arms ___Exercising legs
___ Other: _____

Difficulties with Social and Recreational Activities

___ Bowling ___ Jogging ___ Swimming ___ Ice Skating ___ Competitive Sports ___ Dating ___ Golfing
___ Dancing ___ Skiing Roller skating ___ Hobbies ___ Dining out ___ Other: _____

Difficulties with Functional Activities

___ Carrying small objects ___ Lifting weights off floor ___ Carrying large objects ___ Lifting weights off table
___ Carrying brief case __ Climbing stairs ___ Carrying large purse ___ Climbing inclines seated
___ Pulling things white standing ___ Exercising arms ___Exercising legs
___Other: _____

Difficulties with travelling

___ Riding as passenger in a motor vehicle ___ Riding as a passenger on a train
___Riding as a passenger on an airplane

Use the following 1 to 5 scale to describe the difficulties below:

1 = "This area is not affected by my condition," **2** = "This area is slightly affected by my condition," **3** = "My condition moderately restricts my ability in this area," **4** =" My condition seriously limits my ability in this area," **5** = "My condition prevents me from using this ability."

Difficulties with Different Forms of Communication

___ Concentrating ___ Hearing ___ Listening
___ Speaking ___ Reading ___ Writing
__ Using a keyboard ___ Other: _____

Difficulties with Hand Functions

___ Grasping ___ Holding ___ Pinching
___ Percussive movements
___ Other: _____

Difficulties with the Senses

___ Seeing ___ Hearing ___ Sense of touch
___ Sense of taste ___ Sense of smell
___ Sensory Discrimination

Difficulties with Sleep and Sexual Function

___ Being able to have normal, restful night's sleep
___ Being able to participate in desired sexual activity

Write in below any additional information regarding your Activities of Daily Living (that wasn't covered above):

_____
_____
_____
_____
_____

Prior Symptom History/ Prior Similar Symptoms

□ **I have NOT had prior symptoms similar to my current complaints.**
□ **My current complaints DID exist before, but had not been bothering me.**
□ **My current complaints ALREADY existed and were worsened.**
My most recent prior similar symptoms (if applicable) occurred_____

Has your History Contributed to your Current Symptoms?

□ **My history HAS contributed to my current symptoms.**
□ **My history HAS *NOT contributed to my current* symptoms.**
□ **I'm NOT SURE if my history has contributed to my current symptoms.** □ Months ago □ Years ago
OR on Date: _____

Write in below any other Prior Symptom History, not covered above:

_____
_____
_____
_____
_____

Cain Chiropractic & Rehab, P.C.
Dr. Karen A. Cain, BA MBA DC
1720 S Bellaire St, Ste. 1210
Denver, CO 80222
Telephone (303) 399-2447
Fax (303) 691-5772

Notice to Insurance Company of Assignment

To: _____ (Ins. Company) Date: _____

Patient: _____

Policy Number: _____

You are instructed to pay the Cain Chiropractic & Rehab, P.C. clinic directly for all professional services rendered to me by this clinic.

Pursuant to Colorado State Law (HB05-1165 effective 9/1/2005); this instruction to you is an assignment of my rights under medical coverage to the extent of state law. THIS INCLUDES ALL CLAIMS, BE THEY 1ST PARTY OR 3RD PARTY CLAIMS.

Any sum of money paid under this assignment shall be credited to my account and I shall be personally liable for any unpaid balance to the clinic. Also, I am personally liable for any unpaid accounts for hospital, diagnostic and consultant services.

Patient's Signature: _____

Address: _____

Witness: _____

Acknowledgment of Insurance Company

This insurance company hereby acknowledges receipt of the above instruction and agrees to mail payment of medical coverage benefits of the policy directly to the office of and to the order of the clinic only.

Signature: _____Date: _____

Title: _____

PARTIAL ASSIGNMENT OF CAUSE OF ACTION

Name: _____

Address: _____

Cell #: _____ Home #: _____ Work #: _____

Nearest Relative

Name: _____

Address: _____

Cell #: _____ Home #: _____ Work #: _____

I, the assignor, assign a part of my cause of action for damages against the responsible party and his or her insurance company for personal injury damages arising from an incident that occurred on or about to Cain Chiropractic & Rehab, P.C., the assignees. If this incident includes a claim with an uninsured (UM) or underinsured (UIM) motorist, I assign a part of my claim against any auto insurance company that may be liable to me for UM or UIM damages to die assignees. This partial assignment of cause of action only assigns the portion of damages that represents my claim for damages for my health care treatment from the assignees. All other damages are not assigned and remain part of my damages that I may pursue individually.

This partial assignment gives the assignees a right to bring a legal action against the responsible party, his or her insurance company and against any UM or UIM insurer in the assignees' own names and I do not have to be a party to this action for the assigned claims. Any payment received and release signed by the assignees from the responsible party or his or her insurance company or from a UM or UIM insurer, will only release the claims for damages that represent my health care treatment by the assignees and all other damages will not be released. I will not have to agree to any settlement or payment between the assignees and the liable parties or insurers and my name is not to be included on any document, check, draft or release for payment of the partially assigned claims. A settlement or payment may be made by the responsible party, his or her insurer or by the UM or UIM insurers without waiting until I have settled or received payment for all other damages not assigned. In the event the insurance policy limits from the responsible party, his or her insurer or from the UM or UIM insurers is insufficient to pay for the assigned claims and my claims for damages not assigned, the assignees are to be paid first and have priority of payment. Any payment made to the assignees from the responsible party, his or her insurer or by the UM or UIM insurers shall be made directly to the assignees. A release signed by the assignees does not in any way release any claims that I have not assigned.

I may bring a legal action for all damages not assigned against the responsible party, his or her insurer or by the UM or UIM insurers regardless of any judgment or settlement obtained or release signed by the assignees. This assignment cannot be revoked unless both the assignor and the assignees agree to a revocation of this assignment in writing.

Patient (Assignor) Signature_____ **Date**_____

If patient is a minor, signature of guardian

Health Care Provider's Lien

Cain Chiropractic & Rehab, P.C.

PATIENT'S PRINTED NAME: _____

DATE OF ACCIDENT/INJURY: _____

Upon receiving proceeds on my behalf, I hereby authorize and direct my attorney(s), to pay directly to Cain Chiropractic & Rehab, P.C. such sums from any settlement, judgement or verdict from my personal injury claim based on the accident referenced above, as may be necessary to pay in full Cain Chiropractic and Rehab, P.C., for services on my behalf.

This lien shall be irrevocable and shall be valid and enforceable out of the net proceeds of my settlement, judgment, or verdict. Net proceeds means the gross amount recovered, less any attorney fees and costs. This lien applies to sums currently owed, and to sums which may be incurred in the future. **I intend for receipt of this document by my attorney to constitute notice to the attorney of this lien and I intend for this lien to be valid and enforceable regardless of whether or not my attorney signs the lien below.**

I fully understand that I am directly and fully responsible to Cain Chiropractic & Rehab, P.C., for all professional bills submitted by Cain Chiropractic & Rehab, P.C., for services rendered to me, regardless of the outcome of my personal injury claim. This agreement is made in consideration of Cain Chiropractic & Rehab, P.C., awaiting payment of the Cain Chiropractic & Rehab, P.C., bills. I understand such payment is not contingent on the outcome of any action against an insurer or any person or entity who may be responsible for the payment of such bills.

Patient: _____ Date: _____

Cain Chiropractic & Rehab, P.C., agrees that in exchange for execution of this lien by the patient, Cain Chiropractic & Rehab, P.C., will refrain from referring any bills for professional services rendered to the patient to any third-party for collection or take any legal action to collect these bills until the personal injury claim is resolved.

The undersigned attorney, for the above referenced patient hereby agrees to withhold such sums from any settlement, judgment and/or verdict and to pay such sums directly to Cain Chiropractic & Rehab, P.C., as required by the terms of this lien.

Attorney Signature: _____ Date: _____

Notice: Please date, sign, and return to Cain Chiropractic & Rehab, P.C. 1720 South Bellaire St., #1210, Denver, Colorado 80222 **Fax: 303-691-5772** - at once, and please keep a copy for your records.

Name: _____ Date: _____

Post-Concussion Syndrome/Mild Traumatic Brain Injury
Symptom Check List

Cognitive ("Thinking Skill") Problems

____ Attention to concentration (mind wanders: easily distracted: cannot keep focus)
____ Short term memory loss, "forgetfulness", or trouble learning new things
____ Trouble remembering old things (remote memory)
____ Finding the right word when talking
____ Understanding what is said and/ or what is read
____ Making decisions or solving problems
____ Planning or organization
____ Making more mistakes than usual or not catching your mistakes
____ Slower speed of thinking
____ Getting lost or disoriented (even in familiar places)
____ Trouble alternating attention or "juggling" several things at once
____ Disorganized or confused thinking

Physical Symptoms

____ Dizziness
____ Periods of "blacking out" or seizures
____ Problems with coordination of hands, feet, or legs (drop things more; balance problems)
____ Stuttering or slurring
____ Change in the senses of smell or taste (circle one or both)
____ Blurry or double vision
____ Ringing in the ears
____ Headaches
____ Headache when reading
____ Fatigue
____ More sensitive to bright light and/ or loud noises (circle one or both)
____ Tingling or numbness in legs or arms (circle one or both)

Emotional Symptoms

____ Feeling of sadness and depression
____ Crying spells or weepiness
____ Suicidal thoughts or intentions
____ Decreased or increased emotions (circle one)
____ Low motivation
____ Decreased or increased sex drive (circle one)
____ Decreased or increased appetite (circle one)
____ Decreased interest in "fun" activities
____ Difficulties with sleeping (getting to sleep or staying asleep)-(circle one or both)
____ Irritability/ easily frustrated
____ Feelings of anxiety or fear

Name: _____ Date: _____

Post-Traumatic Stress Disorder (PTSD)
Symptom Check List

____ Recurrent and intrusive thoughts about the traumatic event

____ Recurrent dreams and nightmares about the traumatic event

____ Acting or feeling like the traumatic event is recurring while awake (e.g. “flashback”)

____ Intense anxiety or panic while in contact with or exposed to things which remind you of the traumatic event (e.g. for individuals involved in a car accident, driving or riding in a car)

____ Avoiding the feared situation or enduring it only with significant anxiety (e.g. avoid driving or riding in a car after a car accident)

____ Avoiding places which remind you of the traumatic event (e.g. avoiding the scene of the accident)

____ The avoidance and/ or anxiety interferes with your relationships, work, and/ or social activities

____ Hypervigilance when reminded of the traumatic event (e.g. hyper alert when driving after a car accident

____ Excessive or unreasonable fear caused by the anticipation of the feared situation (e.g. thinking about driving causes anxiety after a car accident)

ATTENTION PATIENTS
PLEASE READ!!

Cain Chiropractic & Rehab, P.C. Cancellation Policy

$50.00

Patients will be charged for missed
Chiropractic & Massage
Appointments

24 HOUR NOTICE
is required for all appointment
cancellations or rescheduling.

A missed appointment is a loss for all.
These times are reserved exclusively for you.

Appointments are in high demand.
Your early notice will give another
person who is in urgent need of treatment
the opportunity to have access to
timely health care.

Thank you!

I understand and consent to the payment if I do not give at least 24 hour notice of cancellation.

Sign: _____ Date: _____