The Bump Clinic
at Fairchild Family Chiropractic

FAIRCHILD FAMILY CHIROPRACTIC
GETTING BETTER TOGETHER

Patient Information

Patient Name: ____
(LAST) (FIRST) (MIDDLE)

Date of Birth: ______________________________ Sex (circle one): Male Female
(MM/DD/YYYY)

Steet Address: ____

City: ____________________________________ State: __________ Zip Code: ____________________

Phone #: ______________________________ E-mail: ____

Fall Sport: ____________________ School: ______________________ Head Coach: __________________________

Any prior health conditions we should be made aware of: ____________________________________

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Parent or Legal Guardian - Note: if athlete is under the age of 18, a parent or guardian must provide authorization.

Name: ____
(LAST) (FIRST) (MIDDLE)

City: ____________________________________ State: __________ Zip Code: ____________________

Phone #: ______________________________ E-mail: ____

Authorization for Treatment

I agree that the above information is accurate to the best of my knowledge. I hereby give consent to Fairchild Family Chiropractic, LLC and the health professionals employed by or providing services within, to evaluate and treat________________________________ at our Bump Clinic. I am aware that the evaluation and treatment, such as
ATHLETE'S NAME
adjustments, performed during the Bump Clinic hours are provided at no cost to you.

I understand that Fairchild Family Chiropractic is providing this opportunity to have sports-related injuries examined by a Board-Certified Chiropractor and that no guarantees have been made to me regarding treatment. Recommendations may be made including follow-up visits during regular hours, referral to Primary Care Physician (PCP), x-ray or other diagnostic imaging, physical therapy, etc. The costs associated with these recommendations will be the sole responsibility of the athlete or their parent/guardian. Additional services such as those mentioned above, if provided by Fairchild Family Chiropractic or its health care providers, will be charged at our standard rates.

Signature of Patient (or Parent/Guardian if under 18): ________________________________ *Date:* _______________