Please use BLUE or BLACK ink only

BRIGHT life CHIROPRACTIC

2 Park of Commerce Blvd.
Suite D
Savannah, GA 31405
912.777.3717

Name_____Date_____/_____/_____Age_____ Male Female

Address:_____City_____State_____Zip_____

Phone: Home_____Cell_____Cell Phone Provider_____

Email:_____Date of Birth_____/_____/_____

Employer's Name_____Position_____

Single Married Divorced Widowed Spouse's Name_____

Number of Children _____ Names, Ages & Gender_____

Who may we thank for referring you?_____

LIST YOUR HEALTH CONCERNS BELOW

Health Concerns: **List according to severity**	Rate of Severity 1=mild 10 =unbearable	When did this episode start?	If you had the condition before, when?	Did the Problem begin with an injury?	Are symptoms constant or intermittent?
1.					
2.					
3.					
4.					
5.					

HAVE YOU EVER SEEN OTHER DOCTORS FOR THESE CONDITIONS? YES NO

CHIROPRACTOR?_____MEDICAL DOCTOR?_____OTHER_____

WHO AND WHEN?_____

✓ *CHECK ALL CURRENT PROBLEMS YOU HAVE*

ADD/ADHD	**CHEST PAIN**	**HEADACHES**	**LIVER DISEASE**	**NUMBNESS IN FEET**
ALLERGIES	**CHRONIC FATIGUE**	**HEART PROBLEMS**	**LOW BACK PAIN**	**NUMBNESS IN HAND**
ANXIETY	**COLIC**	**HYPERTENSION**	**LUPUS**	**NUMBNESS IN LEGS**
ARM PAIN	**DEPRESSION**	**HIP PAIN**	**MENSTRUAL ISSUES**	**PREGNANCY**
ARTHRITIS	**DIZZINESS**	**IMMUNE DEFICIENT**	**MID BACK PAIN**	**SCIATICA**
AUTISM	**DISC PROBLEM**	**INFERTILITY**	**MIGRAINES**	**SHOULDER PAIN**
AUTO IMMUNE	**EAR INFECTIONS**	**IRRITABLE BOWEL**	**NAUSEA**	**SINUS INFECTIONS**
BLADDER PROBLEMS	**EPILEPSY**	**KIDNEY PROBLEMS**	**NECK PAIN**	**STOMACH ISSUES**
CANCER	**FIBROMYALGIA**	**KNEE PAIN**	**NERVOUSNESS**	**THYROID PROBLEMS**
OTHER_____	**GASTRIC REFLUX**	**LEG PAIN**	**NUMBNESS IN ARMS**	**VERTIGO**

✓ *CHECK ANY CONDITION THAT YOU HAVE NOW OR HAVE HAD IN THE PAST*

STROKE **HEART DISEASE** **SPINAL SURGERY** **SEIZURES** **SPINAL FRACTURE** **SCOLIOSIS** **DIABETES**

LIST ALL SURGICAL OPERATIONS AND YEARS_____

_____

LIST ALL OVER THE COUNTER & PRESCRIPTION MEDICATIONS YOU ARE ON_____

_____

_____

WHEN WAS YOUR LAST AUTO ACCIDENT_____

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? YES/NO

IF YES, DR AND DATE_____

HAVE YOU EVER BEEN KNOCKED UNCONSCIOUS? YES/NO FRACTURED A BONE? YES/NO

IF YES, PLEASE DESCRIBE_____

OTHER TRAUMA_____

SOCIAL HISTORY

1. SMOKING: ___cigars ___pipe ___cigarettes → How often? ___Daily ___Weekends ___Occasionally ___Never

2. EXERCISE: How often? ___Daily ___Weekends ___Occasionally ___Never

3. How does your present problem affect the following: **HOBBIES – RECREATIONAL ACTIVITIES – EXERCISE**

_____

4. CHECK ANY ACTIVITIES OF DAILY LIVING ARE BEING RESTRICTED BY YOUR CURRENT HEALTH PROBLEMS:

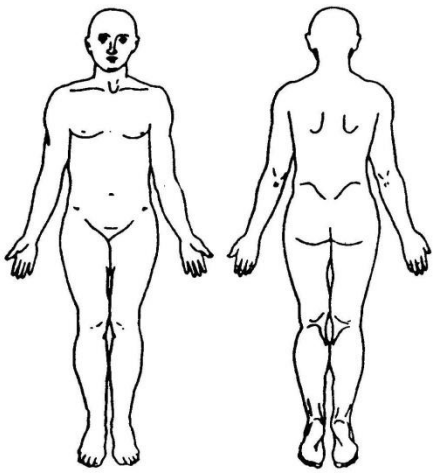
Bathing/Showering **Personal Hygiene** **Walking**
Toilet Hygiene **Self Feeding** **Dressing**

_____

***PLEASE MARK** the areas on the diagram with the following letters to describe your symptoms:

R=Radiating D=Dull N= Numbness
B=Burning A=Aching
S= Sharp/Stabbing

*What relieves your symptoms?*_____
*What makes them worse?*_____



QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please read carefully:

Instructions: Please check the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

1 – What is your pain RIGHT NOW?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

2– What is your TYPICAL or AVERAGE pain?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

3– What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

4– What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

Are there health conditions you are afraid this might turn into?

- ☐ Family health problems
- ☐ Heart disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Depression
- ☐ Chronic Fatigue
- ☐ Need surgery

How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:

What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.) Give 3 examples:

What are you most concerned with regarding your problem?

Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific

What would be different/better without this problem? Please be specific

What do you desire most to get from working with us?

What would that mean to you?

Activities of Life

Based on the "EFFECT SCALE" from the previous page, rate how each activity affects you.
Place an "✓" in the box to mark your rating. Use "N/A" for any activity Not Applicable to you (or your child).

PERSONAL HYGIENE & DAILY CARE

ACTIVITY	RATING				ADDITIONAL NOTES:
	No effect	Painful (can do)	Painful (limits)	Unable to perform.	
Bathing / Showering	☐	☐	☐	☐	
Grooming Hair	☐	☐	☐	☐	
Brushing Teeth	☐	☐	☐	☐	
Using The Toilet	☐	☐	☐	☐	
Dressing The Upper Body	☐	☐	☐	☐	
Dressing The Lower Body	☐	☐	☐	☐	

DAILY PHYSICAL ACTIVITIES

ACTIVITY	RATING				ADDITIONAL NOTES:
	No effect	Painful (can do)	Painful (limits)	Unable to perform.	
Standing	☐	☐	☐	☐	
Sitting	☐	☐	☐	☐	
Squatting	☐	☐	☐	☐	
Kneeling	☐	☐	☐	☐	
Reaching Overhead	☐	☐	☐	☐	
Bending Forward	☐	☐	☐	☐	
Turning Left	☐	☐	☐	☐	
Turning Right	☐	☐	☐	☐	
Move From Lying to Sitting	☐	☐	☐	☐	
Move From Sitting to Standing	☐	☐	☐	☐	
Move From Standing to Sitting	☐	☐	☐	☐	

FUNCTIONAL ACTIVITIES

ACTIVITY	RATING				ADDITIONAL NOTES:
	No effect	Painful (can do)	Painful (limits)	Unable to perform.	
Sleeping	☐	☐	☐	☐	
Eating	☐	☐	☐	☐	
Going Up & Down Stairs	☐	☐	☐	☐	
Getting In & Out of Car	☐	☐	☐	☐	
Driving	☐	☐	☐	☐	
Using A Computer	☐	☐	☐	☐	
Focusing / Concentrating	☐	☐	☐	☐	
Preparing Food	☐	☐	☐	☐	
Household Chores	☐	☐	☐	☐	
Lifting Children	☐	☐	☐	☐	
Carrying Bag / Purse	☐	☐	☐	☐	

SOCIAL, RECREATIONAL & OTHER ACTIVITIES

ACTIVITY	RATING				ADDITIONAL NOTES:
	No effect	Painful (can do)	Painful (limits)	Unable to perform.	
Competitive Sports	☐	☐	☐	☐	
Running / Jogging / Hiking	☐	☐	☐	☐	
Other Recreation Activities	☐	☐	☐	☐	
Hobbies	☐	☐	☐	☐	
Sexual Activity	☐	☐	☐	☐	

PRACTICE MEMBER INFORMATION

MUST BE COMPLETED IN FULL BEFORE SERVICES CAN BE RENDERED

NAME:_____
First Middle Last

PHONE: Home_____Cell_____Work_____

SOCIAL SECURITY NUMBER:_____

DATE OF BIRTH:_____

IN CASE OF EMERGENCY CONTACT:_____PHONE NUMBER_____

NAME OF PRIMARY INSURANCE CARRIER:_____

NAME OF INSURED:_____INSURED DATE OF BIRTH:_____

INSURED SOCIAL SECURITY NUMBER:_____

NAME OF SECONDARY INSURANCE CARRIER:_____

NAME OF INSURED:_____INSURED DATE OF BIRTH:_____

INSURED SOCIAL SECURITY NUMBER:_____

Insurance Policies and Fee Schedule

- **Consultation**:includes new practice member history. This service is complimentary.
- **Specific, Scientific Chiropractic Assessment** :(new or established practice member):includes one or more of the following: thermography ,surface electromyography, range of motion, motion and/or static palpation, leg check. $75.
- **Specific, Scientific Chiropractic Adjustment**: The actual re-alignment of the misaligned vertebra. Occasionally, a sound may be heard, but if there is no auditory result, it does not mean that the adjustment has not taken place. $35-$60.
- **Chiropractic Postural X-rays:** Specific x-ray views taken of your spine to determine a misalignment/ subluxation of your vertebrae. These can also be used to indicate progress after a period of care. $60 per view.

Release of Authorization/Assignment of Benefits

I authorize and request payment of insurance benefits directly to Jared Brown, D.C. or Samantha Brown, D.C. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

SIGNED_____**DATE**_____

TERMS OF ACCEPTANCE

In order to provide the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art, and practice. It is not the practice of medicine.
B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.
C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day by Doctors of Chiropractic in the United States alone.
D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
E. Chiropractic does not seek to replace or compete with your medical, dental, or other types of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic care.
G. We invite you to speak frankly to the doctor on any matter related to your health care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting open environment.

By my signature below, I have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

Signature _____ Date _____

Notice of Privacy Practices Acknowledgement

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Bright Life Chiropractic or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal health care operations, such as quality assessments and physician certifications.

I acknowledge that I have received a full copy of our NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose, to carry out treatment, payment, or health care operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Signature _____ Date _____

INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARILY TO CHIROPRACTIC CARE INCLUDE: SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE OCCURING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER TWO MILLION CERVICAL SPINE (NECK) ADJUSTMENTS MAY BE A VERTEBRAL INJURY THAT COULD LEAD TO A STROKE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR, YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NEEDED OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

_____

PRINT PRACTICE MEMBER NAME

_____ _____

PRACTICE MEMBER'S SIGNATURE **DATE**

IF THIS HEALTH PROFILE IS FOR A MINOR/CHILD, PLEASE FILL OUT AND SIGN BELOW

WRITTEN CONSENT FOR A CHILD

NAME OF PRACTICE MEMBER WHO IS A MINOR/CHILD_____

I AUTHORIZE DR. JARED BROWN AND/OR DR.SAMANTHA BROWN AND ANY AND ALL BRIGHT LIFE CHIRORPACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATION, RENDER CHIRORPACTIC CARE AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR/CHILD.

AS OF THIS DATE, I HAVE THE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY MINOR/CHILD. IF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATLEY NOTIFY BRIGHT LIFE CHIROPRACTIC.

_____ _____

DATE GUARDIAN SIGNATURE AND **RELATIONSHIP TO MINOR CHILD**

_____ _____

DATE BRIGHT LIFE CHIROPRACTIC WITNESS SIGNATURE

Medical Information Release Form
(HIPAA Release Form)

Name: _____ **Date of Birth:**_____

Release of Information:

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages:

Please call [ ] my home [ ] my work [ ] my mobile number: _____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*) _____ between (*time*) _____

Signed: _____ Date: _____

Bright Life Chiropractic representative: _____ Date: _____

Bright Life Chiropractic
Dr. Jared Brown
2 Park of Commerce Blvd. Suite D
Savannah, GA 31405
Phone:912.777.3717
Fax: 912.349.7266

To: _____ Date:_____

_____

_____

_____

From: Bright Life Chiropractic

Please forward to the address above:

☐ X-Rays and Reports

☐ Medical Records

I, _____, authorize any doctor, hospital, employer, or other person whom a signed copy or a photocopy of this authorization is delivered, to furnish any information, reports or copies of records which may be requested by Bright Life Chiropractic.

DOB:_____

Signature_____Date_____

Unless otherwise noted, this authorization expires 90 days from date signed.

_____ Date_____

Bright Life Rep.

FAMILY HEALTH HISTORY

THIS FORM IS TO ASSIST THE DOCTORS BY PROVIDING PAST HEALTH HISTORY INFORMATION FOR THEIR REVIEW.

_____ _____

PLEASE PRINT YOUR NAME HERE **DATE**

PLEASE PLACE AN "X" IN THE APPROPRIATE BOXES BELOW

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
ARM PAIN					
ARTHRITIS					
ASTHMA					
ADHD					
ALLERGIES					
BACK TROUBLE					
BEDWETTING					
CANCER					
CARPAL TUNNEL					
DECEASED					
DIABETES					
DIGESTIVE PROBLEMS					
DISC PROBLEMS					
EAR INFECTIONS					
FIBROMYALGIA					
HEADACHES					
HEARTBURN					
HIGH BLOOD PRESSURE					
HIP PAIN					
LEG PAIN					
MENSTRUAL DISORDER					
MIGRAINES					
NECKPAIN					
SCOLIOSIS					
SINUS TROUBLE					
SURGERIES					
TMJ					

X-RAY AUTHORIZATION

AS YOUR HEALTH CARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC HEALTH RECORDS. WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES.

AT YOUR REQUEST, WE WILL PROVIDE A COPY OF YOUR X-RAYS IN OUR FILES.

THE FEE FOR COPYING YOUR X-RAYS ON A DISC IS $15.00. THIS FEE MUST BE PAID IN ADVANCE.

DIGITAL X-RAYS ON CD WILL BE AVAILABLE **WITHIN 72 HOURS** OF PREPAYMENT ON ANY REGULAR PRACTICE HOURS DAY. **PLEASE NOTE**: X RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE **VERTEBRAL SUBLUXATIONS**. THESE XRAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF BRIGHT LIFE CHIROPRACTIC DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS. HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO THATYOU CAN SEEK PROPER MEDICAL ADVICE.

PRINT YOUR NAME HERE _____ **DATE** _____

SIGNATURE _____ **Date of Birth** _____

FEMALE PATIENTS ONLY: TO THE BEST OF MY KNOWLEDGE, **I BELIEVE I AM NOT PREGNANT** AT THE TIME X-RAYS ARE TAKEN AT BRIGHT LIFE CHIROPRACTIC.

SIGNATURE _____ **DATE** _____

Sex: ☐ **Male** ☐ **Female**

☐ **LatCervical** ☐ **Flex/Ext**

CM	Kvp	Time	MAS
☐10-11	☐78	☐1/24	12.5
☐12-13	☐	☐1/20	15
☐14-15		☐1/15	20
☐16-17		☐1/10	30
		☐2/15	40

MA300 Size8x10

☐ **LowerCervical**

CM	Kvp	Time	MAS
☐14-15	☐70	☐1/10	20
☐16-17	☐	☐2/15	30
☐18-19		☐3/20	40
☐20-21		☐2/10	50
☐22-23			

MA300 Size8x10

☐ **APOM**

CM	Kvp	Time	MAS
☐14-15	☐70	☐1/10	20
☐16-17	☐	☐2/15	30
☐18-19		☐3/20	40
☐20-21		☐2/10	50
☐22-23			

MA300 Size8x10

Other

View _____

CM ___ Kvp ____

MAS ___ MA ____

Size _____

☐ **A-PThoracic**

CM	Kvp	Time	MAS
☐16-17	☐75	☐1/20	17
☐18-19	☐	☐1/15	22
☐20-21		☐1/10	30
☐22-23		☐2/15	40
☐24-25		☐2/10	50
☐26-27		☐1/4	75
☐28-29		☐3/10	90
☐30-31		☐2/5	120
☐31-32		☐	

MA300 Size14x17

☐ **LateralThoracic**

CM	Kvp	Time	MAS
☐22-23	☐80	☐1/15	20
☐24-25	☐	☐1/10	30
☐26-27		☐2/15	40
☐28-29		☐2/10	50
☐30-31		☐1/4	75
☐32-33		☐3/10	90
☐34-35		☐2/5	120
☐36-37		☐1/2	150
☐38-39		☐	

MA300 Size14x17

☐ **A-PLumbar**

CM	Kvp	Time	MAS
☐20-21	☐76	☐1/15	40
☐22-23	☐78	☐1/10	50
☐24-25	☐80	☐2/15	75
☐26-27	☐	☐2/10	90
☐28-29		☐1/4	120
☐30-31		☐3/10	150
☐32-33		☐2/5	120
☐34-35		☐1/2	170
☐36-37		☐3/5	210
☐38-39		☐4/5	
☐40-41		☐1	
☐42-43		☐1½	
		☐2	

☐ **LateralLumbar**

CM	Kvp	Time	MAS
☐26-27	☐88	☐2/10	30
☐28-29	☐90	☐1/4	40
☐30-31	☐92	☐3/10	50
☐32-33	☐94	☐2/5	75
☐34-35	☐96	☐1/2	90
☐36-37		☐3/5	120
☐38-39		☐4/5	160
☐40-41		☐1	200
☐42-43		☐1½	
		☐2	

MA300 Size14x17

Notes:

Report of Findings is scheduled for:

_____

CA Initials:

_____

Photograph & Video Release Form

Bright Life Chiropractic

I hereby grant permission to the rights of my image, likeness and sound of my voice as recorded on audio or video tape without payment or any other consideration. I understand that my image may be edited, copied, exhibited, published or distributed and waive the right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image or recording. I also understand that this material may be used in diverse educational settings within an unrestricted geographic area.

Photographic, audio or video recordings may be used for the following purposes:

- conference presentations
- educational presentations or courses
- informational presentations
- on-line educational courses
- educational videos

By signing this release, I understand this permission signifies that photographic or video recordings of me may be electronically displayed via the Internet or in the public educational setting.

I will be consulted about the use of the photographs or video recording for any purpose other than those listed above.

There is no time limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed.

This release applies to photographic, audio or video recordings collected as part of the sessions listed on this document only.

By signing this form, I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material for educational purposes.

Full Name_____

Street Address/P.O. Box_____

City _____

Prov/Postal Code/Zip Code_____

Phone _____ Fax _____

Email Address_____

Signature_____ Date_____

If this release is obtained from a presenter under the age of 19, then the signature of that presenter's parent or legal guardian is also required.

Parent's Signature_____ Date_____