WALKER
CHIROPRACTIC

104 WOODLAND RD.
AUGUSTA, GA 30907
706.504.3511
AUGUSTACHIRO.COM
DR. CHRIS J. WALKER, CHIROPRACTOR

WELCOME TO WALKER CHIROPRACTIC

You are about to experience the most popular alternative health care in the world!
Below is a short description of Chiropractic and how it works.

Chiropractic care is a natural approach to healthcare. The body is a machine powered by the nervous system. The brain is the main "computer" which is connected to your spinal cord. The spinal cord is a long wire that runs from your brain to your tail bone. The brain is protected by the skull and the spinal cord is protected by 24 moveable backbones, "vertebrae". Nerves branch off the spinal cord like smaller wires and pass between the backbones. These nerves control the functions and sensations "pain", in every organ, tissue and system in your body. Sometimes the bones in your back can move out of their normal positions and put pressure on nerves causing pain or an organ to function improperly. This condition is known as a "Subluxation". Chiropractors are the only Doctors who are trained in locating and correcting subluxations.

The way Dr. Walker locates subluxations is by first feeling the bones to see if they have moved out of their normal positions. Second, he may take an x-ray to see exactly how much the bones have moved. Once the subluxations are located, Dr. Walker will begin to put the bones back into their normal positions very gently with his hands. The process is painless and the benefits are enormous.

Subluxations left untreated may result in permanent damage. First, the bones out of place cause the spine to move improperly. Second, the nerves with pressure on them begin to deteriorate. Third, the muscles around the area are irritated and begin to spasm. Fourth, the cells that the nerves go to begin to function improperly. Finally, the bones out of place become arthritic, the discs between the bones begin to degenerate, and the joints can no longer function. When this occurs, permanent nerve damage may occur and surgery may be the only answer.

How do subluxations occur? Subluxations occur when there is any type of stress on a person. Physical stress such as accidents and falls are the leading cause. Mental stress such as depression can cause subluxations as well. Irregular sleep patterns and everyday movements may also cause subluxations.

What kind of symptoms will people with subluxations have? Most patients come to Dr. Walker for lower back, shoulder, middle back, neck, arm, leg, hand, and foot pain. Others may even complain of headaches, arthritis, and bursitis. Still others seek Chiropractic care for a variety of other ailments. Ask Dr. Walker if he can help a specific condition. It is important to realize that subluxations do not always hurt. Most patients with subluxations will not have any pain at all! The only way to be sure that someone is subluxation-free is to be examined.

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APPLICATION FOR TREATMENT

Personal Information

Name: ______________________ Today's Date: ___/___/___

Address: ______________________
Street City ZIP State

E-mail Address: ______________________

Birth Date: ___/___/___ Age: ________ Are you Pregnant? Yes ☐ No ☐ ________ # of weeks

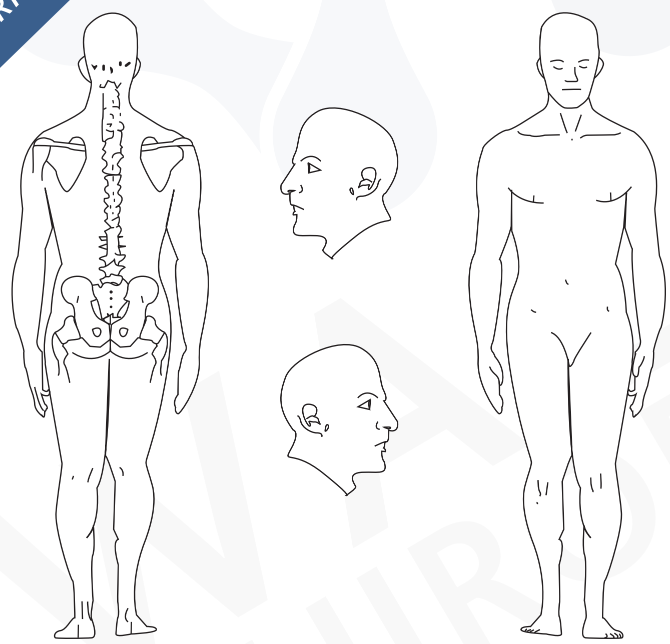
Employer's Name & Address: ______________________

Occupation: ________ Work Phone #: ________ Cell Phone #: ________ Home Phone #: ________

What type of care do you desire: ☐ Temporary Relief ☐ Lasting Correction ☐ Best Care Possible

Personal Information

Please circle the exact location of any pain you are experiencing. Then describe the type of pain, i.e. dull, sharp, constant, on & off, etc.



In order of importance, list the body parts that are bothering you the most:

1) ______________________
2) ______________________
3) ______________________
4) ______________________
5) ______________________

In order of severity, list those body functions that you are unable to perform, or that produce pain upon performance, i.e. walking, sitting, bending, etc.

1) ______________________
2) ______________________
3) ______________________
4) ______________________
5) ______________________

When was the first time you noticed this problem:

____

____

Describe any accidents, falls, injuries, sudden movements, etc. that may have caused your problem:

____

____

Have you had any similar health problems or injuries before? Yes ☐ No ☐ If yes, please explain:

____

____

Name all the doctors you have seen for this problem, and what diagnosis and type of treatment you received (please include where and when you received treatment, and the results):

____

____

____

____

____

(Please complete reverse side)

Has your health problem been: ☐ Improving ☐ Worsening ☐ Staying the Same

Please describe anything you do that improves your condition, or worsens it:

Please check off and describe how this problem interferes with your work and/or personal life:

- ☐ Home Activities Effected:
- ☐ Work Activities Effected:
- ☐ Have you missed any work days? Yes ☐ No ☐ If yes, dates missed:
- ☐ Recreational Activities Effected:
- ☐ Rest or Sleep Effected:

Previous Health History

During the last year, has a doctor treated you for any health problem? Yes ☐ No ☐

If yes, explain:

Have you ever received Chiropractic care? Yes ☐ No ☐ If yes, please list the doctor's name, location of office and for what problems:

Please check off the drugs you are now taking: ☐ Pain Killers ☐ Muscle Relaxers ☐ Anti-inflammatory ☐ Blood Pressure Medication ☐ Insulin ☐ Birth Control Pills ☐ Tranquilizers ☐ Diet Pills ☐ Nerve Medication ☐ Sleeping Pills ☐ Anti-depressants ☐ Other (please list) :

List the approximate dates of any accidents, operations or serious injuries (including broken bones) you have had:

Do you currently have any open cases with an attorney, insurance company, or worker's compensation? Yes ☐ No ☐

If you have been in an automobile accident, when? ☐ This Year ☐ Last Year ☐ Past 5 Years ☐ Over 5 Years

Family Health History

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Names & Ages of Children:

Name of spouse:

Spouse's Employer: Business Phone:

Financial Responsibility

Who is responsible for your bill? ☐ I am ☐ Spouse ☐ My Employer ☐ Insurance ☐ Other:

Type of Insurance: ☐ Worker's Comp. ☐ Health ☐ Automobile

Insurance Company's Name & Address:

If you are responsible for your health care fees, payment will be made by: ☐ Cash ☐ Check ☐ Credit Card

Your fees are due and payable at the time examinations, X-rays, and treatments are received, unless other arrangements have been made in advance. X-rays remain property of this clinic and can be formatted to a disc for a fee of $25.

I, the undersigned, hereby give permission for treatment.

Patient's Signature ______ Social Security No.: ______ Date: / /

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ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

____ACTIVITIES:	EFFECT:			
☐ Carry Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
☐ Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
☐ Climb Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
☐ Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
☐ Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
☐ Lift Children	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
☐ Read/Concentrate	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
☐ Shower	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
☐ Shave	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
☐ Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
☐ Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
☐ Extended Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
☐ Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
☐ Walk	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
☐ Sweep /Vacuum	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
☐ Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
☐ Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
☐ Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
☐ Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
☐ Dress	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
☐ Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
☐ Other: ____________	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

List Prescription & Non-Prescription drugs you take:

____

____

____

Patient Signature:____ Today's Date: ___/___/___

Continued on next page

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REVIEW OF SYSTEMS

Please mark P for in the Past, C for Currently have, or N for Never

______ Headache
______ Neck Pain
______ Jaw Pain, TMJ
______ Shoulder Pain
______ Upper Back Pain
______ Mid Back Pain
______ Low Back Pain
______ Hip Pain
______ Back Curvature
______ Scoliosis
______ Numb/Tingling arms, hands, fingers
______ Numb/Tingling legs, feet, toes
______ Pregnant (Now)
______ Frequent Colds/Flu
______ Convulsions/Epilepsy
______ Tremors
______ Chest Pain
______ Pain w/Cough/Sneeze
______ Foot or Knee Problems

______ Sinus/Drainage Problem
______ Swollen/Painful Joints
______ Skin Problems
______ ADD/ADHD
______ Allergies
______ Dizziness
______ Loss of Balance
______ Fainting
______ Double Vision
______ Blurred Vision
______ Ringing in Ears
______ Hearing Loss
______ Depression
______ Irritable
______ Mood Changes
______ Eating Disorder
______ Trouble Sleeping
______ Prostate Problems
______ Impotence/Sexual Dysfun.

______ Digestive Problems
______ Colon Trouble
______ Diarrhea/Constipation
______ Menopausal Problem
______ PMS
______ Bed Wetting
______ Learning Disability
______ Liver Trouble
______ Hepatitis (A, B, C)
______ Ulcers
______ Heartburn
______ Heart Problems
______ High Blood Pressure
______ Low Blood Pressure
______ Asthma
______ Difficulty Breathing
______ Lung Problems
______ Kidney Trouble
______ Gall Bladder Trouble

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QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name ______________________________ Date ______________

Please read carefully:

Instructions: Please circle 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.

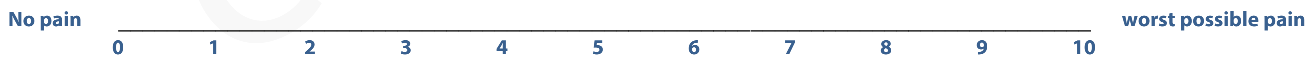
Example:

1 – What is your pain RIGHT NOW?

2 – What is your TYPICAL or AVERAGE pain?

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

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



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.

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INFORMED CONSENT

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Walker Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

________________________________ ____/____/____ Witness Initials

Patient or Authorized Person's Signature Date

REGARDING: X-rays/Imaging Studies

FEMALES ONLY → *Please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-____ (Date)

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

________________________________ ____/____/____ Witness Initials

Patient or Authorized Person's Signature Date

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THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. The Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI.

USE AND DISCLOSURE OF INFORMATION

1. The Practice may use and/or disclose your PHI for the purposes of:

(a) **Treatment**– In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff not, directly involved in your care so that they may understand your health condition and needs. For example, a physician treating you for lower back pain may need to know the results of your latest examination by this office.

(b) **Payment**– In order to get paid for services provided to you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements. For example, the Practice may need to provide the Medicare program with information about health care services that you received from the Practice so that the Practice can be properly reimbursed. The Practice may also need to tell your insurance plan about treatment you are going to receive so that it can determine whether or not it will cover the treatment expense.

(c) **Heath Care Operations**– In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI. For example, the Practice may use your PHI in order to evaluate the performance of the Practice's personnel in providing care to you.

2. The Practice may also use and/or disclose your PHI in the following instances:

(a) **De-identified Information**– Information that does not identify you and, even without your name, cannot be used to identify you.

(b) **Business Associate**– To a business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential functions, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.

(c) **Personal Representative**– To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

(d) **Emergency Situations**–

(i) for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your acknowledgment of our Privacy Notice as soon as possible; or (ii) to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

(e) **Communication Barriers**– If, due to substantial communication barriers or Inability to communicate, the Practice has been unable to obtain your acknowledgment of our Privacy Notice and the Practice determines, in the exercise of its professional judgment, that your consent to receive treatment is clearly inferred from the circumstances.

(f) **Public Health Activities**– Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease.

(g) **Abuse, Neglect or Domestic Violence**- To a government authority if the Practice is required by law to make such disclosure. If the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm.

(h) **Health Oversight Activities**- Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.

(i) **Judicial and Administrative Proceeding**- For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.

(j) **Law Enforcement Purposes**- In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, the Practice may disclose your PHI if the Practice believes that your death was the result of criminal conduct.

(k) **Coroner or Medical Examiner**- The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.

(l) **Organ, Eye or Tissue Donation**- If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.

(m) **Research**- If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI.

(n) **Avert a Threat to Health or Safety**- The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

(o) **Specialized Government Functions**- This refers to disclosures of PHI that relate primarily to military and veteran activity.

(p) **Workers' Compensation**- If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

(q) **National Security and Intelligence Activities**– The Practice may disclose your PHI in order to provide authorized governmental officials with necessary intelligence information for national security activities and purposes authorized by law.

(r) **Military and Veterans**– If you are a member of the armed forces, the Practice may disclose your PHI as required by the military command authorities.

APPOINTMENT REMINDER

The Practice may, from time to time, contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The following appointment reminders are used by the Practice: a) a postcard mailed to you at the address provided by you; and b) telephoning your home and leaving a message on your answering machine or with the individual answering the phone.

DIRECTORY/SIGN-IN LOG

The Practice maintains a directory of and sign-in log for individuals seeking care and treatment in the office. Directory and sign-in log are located in a position where staff can readily see who is seeking care in the office, as well as the individual's location within the Practice's office suite. This information may be seen by, and is accessible to, others who are seeking care or services in the Practice's offices.

FAMILY/FRIENDS

The Practice may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

(a) If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment, that you do not object to the use or disclosure.

(b) If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

AUTHORIZATION

Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

YOUR RIGHTS

1. You have the right to:

(a) Revoke any Authorization, in writing, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.

(b) Request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.

(c) Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.

(d) Inspect and copy your PHI as provided by law. To inspect and copy your PHI, you must submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request. In certain situations that are defined by law, the Practice may deny your request, but you will have the right to have the denial reviewed as set forth more fully in the written denial notice.

(e) Amend your PHI as provided by law. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.

(f) Receive an accounting of disclosures of your PHI as provided by law. To request an accounting, you must submit a written request to the Practice's Privacy Officer. The request must state a time period which may not be longer than six (6) years and may not include dates before April 14, 2003. The request should indicate in what form you want the list (such as a paper or electronic copy). The first list you request within a twelve (12) month period will be free, but the Practice may charge you for the cost of providing additional lists. The Practice will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred.

(g) Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice’s Privacy Officer.

(h) Complain to the Practice or to the Secretary of HHS if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

(i) To obtain more information on, or have your questions about your rights answered; you may contact the Practice's Privacy Officer.

PRACTICE'S REQUIREMENTS

1. The Practice:

(a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

(b) Is required by State law to maintain a higher level of confidentiality with respect to certain portions of your medical information that is provided for under federal law. In particular, the Practice is required to comply with the State statutes:

(c) Is required to abide by the terms of this Privacy Notice.

(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.

(e) Will distribute any revised Privacy Notice to you prior to implementation.

(f) Will not retaliate against you for filing a complaint.

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Dr. Chris J. Walker, Chiropractor

DATE ___/___/___

EFFECTIVE DATE

This Notice is in effect as of today.

By signing below, I acknowledge that I have reviewed the Walker Chiropractic, LLC Privacy Notice and all of my questions have been answered to my satisfaction in language that I can understand.

______________________________	______________________________
Name of Individual (Printed)	Signature of Individual
______________________________	______________________________
Signature of Legal Representative (e.g., Attorney-In-Fact, Guardian, Parent if a Minor)	Relationship
______________________________	______________________________
Date Signed	Witness

If you would like a copy of the Walker Chiropractic, LLC Privacy Notice Check below.

☐ I would like to have a copy of the Walker Chiropractic, LLC Privacy Notice for my records.

For office use below

☐ I have provided a copy of the Walker Chiropractic, LLC Privacy Notice to the above named patient.

104 Woodland Rd.
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HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act ---- 45 CFR Parts 160 and 164)

Patient Name: ____ **SSN:** ____________________

Date of Birth: ______/______/_______ **E-mail Address:** ____

I__________________________________, hereby authorize and request _________________________ ____to release my health information (PHI) to:

Walker Chiropractic
104 Woodland Rd
Augusta, GA 30907
Phone: 706-504-3511 Fax: 706-755-2978

In addition to the authorization for release of my PHI described above this Authorization, I furthermore acknowledge that I have the right to authorize access and disclosure of my Protected Health Information (PHI) to anyone of my choosing for billing, condition, treatment, and prognosis to the following individual(s):

Name ____ Relationship ________________________

Name ____ Relationship ________________________

Name ____ Relationship ________________________

I understand that I am entitled to a copy of Walker Chiropractic's Notice of Privacy Practices. I can access a copy of the Notice of Privacy Practices from the website www.augustachiro.com or from the office directly.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. Unless otherwise revoked this authorization shall be in force and effect one year from today's date at which time this authorization expires.

____

Signature of Patient Date

WALKER CHIROPRACTIC