SHARE YOUR STORY!

BACK COUNTRY CHIROPRACTIC AND WELLNESS CENTER

PATIENT TESTIMONIAL FORM

Thank you for taking the time to share your experience with chiropractic and natural health care with others. Because you have received care from a Doctor of Chiropractic (DC), you are now familiar with the various treatments and health benefits that we offer. Unfortunately, for every one person we help, there are many that continue to suffer simply because they do not know about or understand how chiropractic and other natural treatments can help them.

Through your testimonial, we can educate the public about the chiropractic profession and how many painful and chronic conditions can be treated naturally. Please fill out the questionnaire below regarding your experience at Back Country Chiropractic & Wellness Center. When you are finished, please read and sign the release on the next page that will give us permission to share your testimonial with others.
You may return your completed testimonial on your next scheduled visit to our office or mail it to: BCC & Wellness Center
PO Box 1005
McCall, ID 83638

YOUR STORY… Please describe your health problems before receiving care at our clinic and how these problems affected your daily life and activities. Please include other treatments and/or medications you may have tried prior to coming to our clinic.

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Please tell us which particular treatments you received at our clinic and how these various treatments helped with the improvement of your situation. (i.e., chiropractic manipulations, soft tissue therapy, exercise rehabilitation, diet and nutrition counseling, FirstLine Therapy program, medical foods/supplements, etc.)

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Overall, how has chiropractic and/or other natural treatments benefitted you and how has your daily life improved since receiving this care? Please include any problems that may have improved during the time you were treated that you did not expect would be helped.

Would you recommend Back Country Chiropractic & Wellness Center to others? What would you say to a friend or relative who was curious about chiropractic and natural health care?

When it comes to the care you have been provided, what do you consider to be the most valuable aspect of your experience with us? (i.e., amount of time spent with you, chiropractic manipulations and treatments, quality of care, etc.)

If you've had experience with other chiropractors and/or natural healthcare providers, what sets us apart from them?

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Patient Testimonial Release Consent

Purpose of Consent: By signing this form, you are consenting to Back Country Chiropractic & Wellness Center's (BCC & WC) use and disclosure of the information in your testimonial and acknowledgement that the testimonial may be distributed to the public.
Right to Revoke: You have the right to revoke this Release at any time by giving us written notice of your revocation and submitting it to the Contact Person listed below. Please understand that revocation of this Release will not affect any action BCC & WC took in reliance on this Release before receiving your revocation. (Contact Person: Dr. Irwin Mulnick)

CONSENT TO RELEASE

I hereby authorize BCC & WC to use my testimonial and any information in the testimonial in its public relations efforts. I understand and approve the disclosure by BCC & WC of testimonial information to the media and other individuals and entities that may be involved in BCC & WC's public relations efforts.
I understand that I am providing the testimonial information to BCC & WC and that my treating physician will not be providing any protected information to the media or public, including private health information in my medical records, the confidentiality of which may be protected by federal and state statutes and regulations, including the Health Insurance Portability and Accountability Act (HIPAA).
I waive the right of prior approval and hereby release BCC & WC from all claims for damages of any kind based on the use of my testimonial or information in the testimonial.
I am of legal age and freely sign this release, which I have read and understood. I also acknowledge that I have not been paid or compensated in any way for my testimonial.

Patient Signature _____ **Date** _____

Please provide your contact information.

Name _____

Address _____

City, State, ZIP code _____

Phone _____

Email _____

“We sincerely thank you for taking the time to share your experiences with others! Best of Health!”