



Erin O' Connor, D.C., C.A.C.
768 Shoreline Dr., Aurora, IL 60504
P: (630)499-4078 F: (630)496-7012

Date: _____

Veterinarian: _____

Clinic/Hospital: _____

Phone: _____ Fax: _____

Dear Doctor,

The following client has chosen chiropractic care for the following animal(s):

Client Name: _____

Patient Name: _____

Species: _____ Breed: _____

Age: _____ Sex: M / N F / S

Please contact me if you would like a follow up report for your records.

Sincerely,

Erin O'Connor, D.C., C.A.C.

•Dr. O'Connor is a licensed chiropractor who completed 220+ hrs of education specifically in animal chiropractic, along with staying up to date with required continuing education in animal chiropractic, and is board certified through the American Veterinary Chiropractic Association (AVCA). Since February 2010, she has exclusively treated animals full time.

•Animal chiropractic offers a complementary method of care and does not replace traditional veterinary medicine. All of Dr. O'Connor's patients are required to stay up to date with their veterinarian.

•This document is for your records and in accordance with Public Act 93-0281.
(See amendment to Senate Bill 386)

I acknowledge that my client wants their animal seen by Dr. Erin O'Connor for chiropractic care. I also understand that if I would like more information on this animal for my records, or about animal chiropractic in general, I can request it.

Veterinarian's Signature

Date

Please sign and fax to (630)496-7012. Thank you!



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Dear Doctor,

You are receiving this form to decide what type of correspondence you would like from Vitality Chiropractic regarding any of your patients seeking chiropractic care. This document is for your records and is in accordance with Public Act 93-0281. (See amendment to Senate Bill 386)

Please choose one:

_____ Dr. O'Connor will have a document/letter faxed and signed by you for treatment of each patient seeking care at our clinic. (page 1 of this fax)

OR

_____ Dr. O'Connor is asking for your cooperation in signing one letter of acknowledgement and permission for treatment of any patients from your clinic/hospital seeking care.

With either choice, if you would still like information on a certain patient for your records, you may request it at anytime. Also, if at any time you would like to change your method of correspondence chosen above or customize it in any way to your liking, please let us know. We are happy to accommodate your needs.

Veterinarian's Name

Veterinarian's Signature

Date

* Please sign and fax to: (630)496-7012. Thank you! *