Welcome To A.V. CHIROPRACTIC HEALTH CENTER

PERSONAL HISTORY

Date: /___/___

MR. MS. MRS. MISS DR. NAME:_____
CIRCLE ONE FIRST MIDDLE LAST

Home #_____ Work #_____ Cell#_____ Cell Phone Company_____

E-mail:_____ Sex: M F Birth Day ___/___/____ Age:_____

ADDRESS:_____CITY:_____ STATE_____ ZIP_____

Employer:_____ Occupation_____ DL# _____

Nick Name_____ Your SSN# _____-_____-_____ Spouse's SSN# _____-_____-_____

Single Widowed Divorced Separated Married - Spouse Name_____ Children Ages ____,____,____,____

Emergency Contact: _____Phone: _____Relationship_____

Minor - Patients Parent or Guardian:_____ Contact #:_____

Method of Payment: Cash Workers' Comp Auto Insurance Medicare Personal Health Ins.
Please Circle One

Who referred you?

Friend/Family :_____

Personal Health Ins.:_____

Are you the primary account holder? Yes / no

Attorney/Law Firm:_____

Workers' Comp:_____

Internet Search: Please circle one

Google Facebook Pinterest Twitter

Yelp Our Site Walk in Drive by

Other:_____

Doctor or Office:_____

HEALTH CONDITION`

Fill in or circle the appropriate answer below

What's your major complaint: _____

When did your condition/ symptoms/pain first appear? (Days, Weeks, Months, Years etc.)_____

Is Condition: Job Related - Auto - Home Injury - Fall - Other_____ Date of Accident:_____Time _____

Is this condition getting Worse? Yes - No - Constant - Intermittant.

Have Reported of Your Accident: Yes - No When is it Worse: Morning - Afternoon - Evening - Varies __ _____

Does it interfer with: Work - Sleep - Daily Routine - other_____

How long has it been since you REALLY FELT GOOD?_____

When did This Condition Begin? _____ Has this condition Occurred Before? YES NO
CIRCLE

Other Doctors Seen For This Condition? YES NO Who & when? _____

Type of Treatment:_____ Results:_____

Does the sympoms/pain Radiate? Yes - no. if yes where, how frequent & how long_____

Do you have: numbness - Tingling - weakness Describe_____

List Body Part & mark severity of your condition/symptom/pain on the scale below

Body part _____ _____ 0 (none) 5 (severe) 10

Body part _____ _____ 0 (none) 5 (severe) 10

Body part _____ _____ 0 (none) 5 (severe) 10

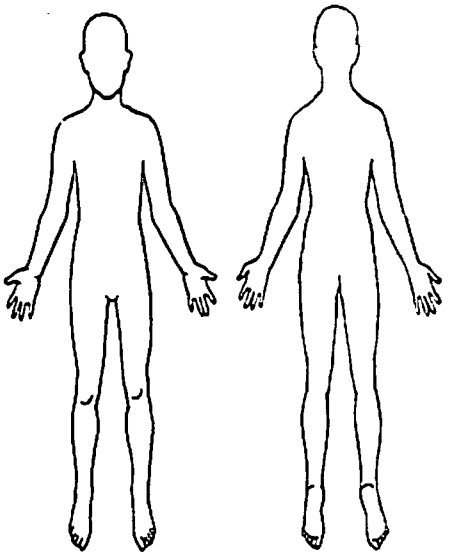
Body part _____ _____ 0 (none) 5 (severe) 10

Do you Wear A Shoe Lift? __ YES __ NO

Name: _____ Date: _____

Type of Pain: Sharp - Dull - Trobbing - Tingling - Numbness - Burning - Aching - Shooting - Other_____

Mark Problem area on body below



What activities or positions Aggravate your condition?

Bending - Coughing - Getting up/down - Driving - Lifting - Turning Head
Lying Down - Sneezing - Standing - Walking - Twisting- Straining @ stool

What Activities or Position relieves your condition?

Heat - Lying down - Sitting - Stretching - Ice - Medication
Massage - Standing - Exercise - Chiropractic - Physical Therapy

Health History

Have you ever had this condition before? Yes - No When_____

List any vitamins, herbs & supplements:_____

_____

When was your last: Physical exam_____ Blood/Lab work _____
X-rays/CT/MRI _____

Do you have any Allergies? (food, contact, enviromental)_____

Drugs You Take: Nerve Pills - Pain Killers/Muscle Relaxers - Blood Pressure - Prescription Meds - Over counter Med - Insulin - Other _____

Major Surgery/Operations: Appendectomy - Tonsillectomy - Gall Bladder - Hernia - Back Surgery - Broken Bones - Heart - Cancer –Other_____

Do you Suffer From Any other Condition not listed? _____ Major Accidents or Falls_____

Hospitalization (other then above):_____Previous Chiropractic Care: Yes - None, Who & when _____

Have you Ever had or do you have any of the following conditions or Diseases? (Circle any to indicate yes)

AD/HD	Carpal Tunnel	Digestive/Bowel probem	Herpes	Rotator cuff prob
Adrenal disorder	Celiac Disease (gluten)	Dizziness or Vertigo	High Blood Pressure	STI/STD
Anxiety	Chest Pain	Ear Infections	Hip Replacement	Shoulder Surgery
Arthritis	Chronic Fatigue	Fibromyalgia	HIV/AIDS	Spinal Surgery
Asthma	Cold Hands or Feet	Food Sensitivity	Kidney Disease	Stroke/TIA
Autoimmune disorder	Colitis/Diverticulitis	Fusions (spinal, joint)	Knee Surgery	Thyroid problems
Bleeding disorder	Compression Fractures	Gout	Liver Disease	Tuberculosis
Blurred Vision	Connective tissue disease	Gall Bladder problems	Marfan's Syndrome	Other_____
Bladder Problems	COPD	Immune Compromise	Multiple Sclerosis	_____
Buzzing or ringing ears	Depression	Heart Disease	Osteoporosis/penia	_____
Cancer_____	Diabetes	Hepatitis (A, B, C)	Parkinson's Disease	_____

Are there any conditions that run in your Family? Yes - No , What condition & which family members? _____

Personal & Social Health History

Are you currently Pregnant, or do you think you may be? Yes - No (if yes, how many weeks)_____ -How many hour a week do you work_____

How do you rate your eating habits? Excellent - Pretty good - Could be better - Needs Improvement

How well do you sleep? Excellent - Pretty good - Restless - Can't sleep - Wake often. How many hours do you sleep daily? _____

Have you ever been to a Chiropractor before: N - Y

Agreement

I understand & agree that health & accident insurance policy's are an agreement between an insurance carrier & me. Furthermore, I understand that the doctor's office will prepare any necessary reports and form to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate treatment, any fees for professional services rendered me will be immediately due and payable. I agree to the open room treatment. I understand there are open computers in the open treatment rooms that the doctor inputs my information in too and there is a sign in sheet and multiple signup sheets for different classes that are visible to others. I also agree to getting Emails & text messages about my appointments.

I hereby authorize the doctor to treat my condition as he or she deems appropriate through use of manipulation throughout my spine. It is understood and agreed that the amount paid to the doctor is for examination and x-rays only. The X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patient's Signature:_____ Date:_____

Parent's or Guardian's Signature of Authorization:_____ Date:_____

As Parent or Guardian of the above patient, I give my permission for this Clinic/Doctor to examine and/or treat.

Update Patient Information

We are in the process of updating our records to comply with federal standards. Please answer the following questions.

Name: _____ **Date:**_____

Height_____ Weight_____ BP _____

Preferred Language?
English
Spanish
Other: _____

Race?
White
Black or African American
Asian
Native Hawaiian or Other Pacific Island
Other Race

Ethnicity?
Hispanic or Latino
Not Hispanic
Other Ethnicity

Smoking Status?
Current every day smoker
Current some day smoker
Former smoker
Never Smoker

Do you have any medication allergies?
No known medication allergies
Yes…
What? _____
What? _____
What? _____

Are you currently taking any medicatons?
Not currently prescribed any medication
Yes ..
What? _____
What? _____
What? _____
What? _____
What? _____

Name: _____ Date: _____

Chiropractic Informed Consent to Treat

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-ray (s) and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for or associated with, or serving as back-up for the doctor of chiropractic named below.

I understand and am informed that, as with any healthcare treatments, results are not guaranteed and there is no promise of a cure. I further understand that, as with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risk and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure (s) which the doctor feels at the time, based upon the facts then known, and are in my best interest.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose, and risks of chiropractic adjustments and other recommended procedures and have had questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read ( ) or have had read to me ( ) the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and I have decided that it is in my best interest to undergo the chiropractic treatment recommended.

Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition (s) for which I seek treatment.

Name of Patient: _____
Signature of Patient: _____
Printed Name of Guardian/Parental and Relation To Patient: _____
Guardian/ Parental Signature: _____
Date: _____
Doctor of Chiropractic Name: _____
Signature of Doctor of Chiropractic: _____
Date: _____

AV Chiropractic Health Center

Financial Policy

We offer several methods of payment for your chiropractic car and you may choose the plan which best suits your needs. Please read carefully and choose the plan which you prefer. This information will enable us to better serve you and help us to avoid misunderstandings in the future. If special financial arrangements are necessary, please consult with the business manager/ doctor during your initial consultation.

OUR MAIN CONCERN IS YOUR HEALTH AND WELL-BEING AND WE WILL DO OUR BEST TO HELP YOU.

PLAN ONE:

The **self-pay** plan means that all fees will be paid when rendered. Fees are discounted for payment at the time of service

PLAN TWO:

If you have **insurance**, we will bill for you as a courtesy. Payment for deductibles, if it has not been met is the responsibility of the patient as well as any copayment or remaining balance after insurance payment. We do participate in many insurance plans that may allow nominal out of pocket expense. **Your co-pay is due as services are rendered.** You are also responsible for portions of your bill that exceed your insurance limits.

Credit Cards will be accepted for all or partial payment.

If care is discontinued, the balance for care received up to that date is due in full in 30 days.

I understand that all responsibility for payment of services provided in this office or myself or my dependents is min, due and payable at the time of services are rendered unless other arrangements have been made. I permit this office to endorse co-issued remittances for the conveyances of credit to my account. In the event payments are not received by the agreed upon dates, I understand that a % finance account is turned over for collection.

PLEASE ADVISE WHICH PLAN YOU WOULD LIKE TO USE: _____

Please sign below to indicate your understanding of our financial policies. If you do not understand, please allow us to review the policies with you until they are clear.

Signature_____Date:_____

Print Name _____

Witness _____ Date:_____

_____

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT 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. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The privacy of PHI in patient files will be protected when the files are taken to and from the Practice by placing the files in a box or brief case and kept within the custody of a doctor or employee of the Practice authorized to remove the files from the Practice's office.

NO CONSENT REQUIRED

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 or not, directly involved in your care so that they may understand your health condition and needs.
(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.
(c) Health 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.

The Practice may use and/or disclose your PHI, without a written Consent from you, in the following additional 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 function, 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 Consent 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 Consent 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 and that does not identify you and, even without your name, cannot be used to identify you.

(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 and that does not identify you and, even without your name, cannot be used to identify you.

(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) 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.

Appointment Reminders

- Your health care provider or a staff member may disclose your health information to contact you to provide appointment reminders. If you are not at home to receive an appointment reminder, a message will be left on your answering machine, voice mail, or with the person who answers the call.
- You have the right to refuse us authorization to contact you to provide appointment reminders. If you refuse us authorization, it will not affect the treatment we provide to you.

Sign-in Log

This Practice maintains a sign-in log for individuals seeking care and treatment in the office. This sign-in sheet 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 unless you direct the Practice to the contrary. 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.

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AUTHORIZATION

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

Your Right to Revoke Your Authorization
You may revoke your authorization to us at any time; however, your revocation must be in writing.

Restrictions
You may 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

You Have a Right to

Inspect and obtain a copy your PHI as provided by 45 CFR 164.524. To inspect and copy your PHI, you are requested to 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.

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.

Prohibit report of any test, examination or treatment to your health plan or anyone else for which you pay in cash or by credit card.

Receive an accounting of disclosures of your PHI as provided by 45 CFR 164.528. The request should indicate in what form you want the list (such as a paper or electronic copy)

Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's Privacy Officer.

Request copies of your PHI in electronic format if this office maintains your records in that format.

Amend your PHI as provided by 45 CFR 164.528. 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.

Receive notice of any breach of confidentiality of your PHI by the Practice

Complain to the Practice or to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201, 202 619-0257, email: ocrmail@hhs.gov 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 acknowledge that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

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PRACTICE'S REQUIREMENTS

1. The Practice:

- 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.
- Is required to abide by the terms of this Privacy Notice.
- Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.
- Will distribute any revised Privacy Notice to you prior to implementation.
- Will not retaliate against you for filing a complaint.

Patient Signature:_____ Date:_____

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California and federal law, and not by a lawsuit or resort to court process except as California and federal law provide for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the healthcare provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the healthcare provider and/or other licensed healthcare providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the healthcare provider, including those working at the healthcare provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the healthcare provider, and/or the healthcare provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's equal share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). The parties further agree that, where not in conflict with this agreement, the Arbitration Rules of ADR Services, Inc. shall govern any arbitration conducted pursuant to this Arbitration Agreement. A copy of the ADR Services rules are available on its website at www.adrservices.com or by calling 213-683-1600 to request a copy of the rules.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the healthcare provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Patient Name (print): _____ Signature: _____ Date: _____

Parent or Guardian (print): _____ Signature: _____ Date: _____

Office Name: _____ Signature: _____ Date: _____

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures, if indicated. Any examinations or tests conducted will be carefully performed, but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including, but not limited to, hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people, whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE