TERMS OF ACCEPTANCE

EXPLANATION OF SERVICES

- Routine activities regularly cause misalignments of the spine. These misalignments, otherwise known as subluxations or joint dysfunctions, create an interruption in the communication between the brain and the different body parts that it goes to via the spine. This can cause decreased joint motion, which generates inflammation causing pain or discomfort, but most importantly, it can cause a decrease in the overall function of the body's ability to function to its optimum potential.

- As Chiropractors, we focus on the nervous system itself. We find these misalignments to provide the patient with a better and more natural pathway in order to aid with better health. Our number one concern is the health and safety of the people we serve. Therefore, we only accept those patients determined to have the potential to benefit from our care. To receive the most from the services provided, it is important to better understand what we do and don't do:

WHAT WE DO

- We provide the public with an affordable and convenient portal of entry to wellness through routine chiropractic care often resulting in better function, improved joint motion, and healthier, more active lifestyle.
- We accomplish out goal through the gentle application of a targeted movement where and when indicated by licensed Chiropractors to improve motion of the body's spinal column and extremities. This is commonly referred to as an adjustment or manual manipulation.

WHAT WE DON'T DO/ LIMITATION OF SERVICES

- We do not offer to treat any disease or condition other than dysfunctions associated with the spine and extremities.
- We do not accept or bill insurance, Medicare, and/or any third party carrier for payment.
- We do not provide invasive testing/treatment or administer physiotherapies such as cold laser, electrical muscle stimulation or ultrasound.
- Our services are limited to the reparative/preventative effects of routine care by improving joint function in the spine and extremities.
- In the doctor's professional opinion, should any additional diagnostic testing, or other forms of health care services, they will be referred to an appropriate provider or facility, when indicated.

FINANCIAL RESPONSIBILITY

Upon completion of the first visit, all patients are required to pay $195.00 which includes consult, neurological exam and x-rays of only one zone, if additional zones are required, they will be extra. After the initial visit, the cost may vary if paid per visit, monthly or in full. Any muscle work, cupping, decompression or etc., will be additional cost. We accept cash, Visa, Mastercard, and Health Savings account (HSA).

All patients acknowledge that they are financially responsible to remit payment in full for all services provided to them. All patients further understand and agree that they will not submit any billing data or related claim(s) for, or on, their behalf to any private insurance program, Medicare or any Secondary Medicare Insurance Program carrier with whom they have insurance coverage.

24 HOUR NOTICE

In order to better serve our patients, each appointment time has been set aside for you. This time is unavailable to other patients. Therefore, we require at least 24 hours advance notice if you need to cancel your appointment. For all missed or cancelled appointments with less than 24 hours notice, you will be charged $27.00 cancellation fee with the card that is on record in your file. Appointment reminder calls are a courtesy. Should you not receive a reminder text message, it is still your responsibility to remember your appointment.

I,_____(Patient Name) have read and fully understand the above statements, and all questions regarding the doctors's objectives pertaining to my care have been answered to my complete satisfaction. I therefore accept all chiropractic care provided to me at this location based upon these guidelines.

Patient Signature _____ Date _____

PATIENT INFORMATION

First Name:_____ Last Name:_____

Seguro Social #:_____-_____-_____ License Number _____

Sex: ____ M ____F

Date of Birth:(MM) _____/(DD)_____/(YYYY)_____ Age: _____

Home Address:_____

City:_____ State:_____ Zip code:_____

Cellphone #:_____ Work Phone #: _____

Email: _____

Emergency Contact: Name_____ Telephone #:_____

Are you Medicare Eligible? (Please Circle One) Yes No

Occupation :_____ Years of Occupation:_____

Have you gone to a Chiropractor before? Yes No

If your answer is yes, when and what was the reason?

_____

How did you hear about Vital Chiropractic Clinic?

_____

If someone referred you please let us know the name of the person to personally thank them. Thank you for choosing Vital Chiropractic Clinic!!!

_____

Patient Signature: _____ Date:_____

PATIENT HISTORY

Describe the reason for your visit today:

_____

_____

When did you first notice your symptoms?_____ What caused it?_____

How is your condition now? (Please circle one) Better Worse Same Comes & Goes

When does it occur? (Please circle one) Morning Afternoon Evening/Night

How often does it occur?_____

How long do your symptoms last?_____

Does your pain travel? (Please circle one) Yes No If so, where?_____

What makes it WORSE?

___ Driving
___ Walking
___ Sitting
___ Bending
___ Standing
___ Bowel Movement
___ Other:_____

___ Breathing
___ Coughing
___Sleeping
___ Working
___ Exercise

What makes it BETTER?

___ Chiropractic
___ Rest
___ Lying Down
___ Sitting
___ Standing
___ Walking
___ Other:_____

___ Heat
___ Stretching
___ Massage
___ Nothing
___ Medication
___ Ice

Rate your pain TODAY: (Please circle one)

(Nothing) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Rate your pain on AVERAGE: (Please circle one)

(Nothing) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

My Condition interferes with: (Circle all that apply)

Work Sleep Daily Routine Other Activities

Have you had this condition before? Yes No If so, when?_____
Have you seen another doctor for this? Yes No If so, when?_____
Doctor's name:_____ Phone #: _____

Were x-rays or any other imaging studies performed? Yes No
What type of imaging?_____
Type of treatment/results: _____

HEALTH HISTORY

PLEASE CIRCLE ALL OF THE FOLLOWING THAT APPLY TO YOU:

Recent Fever	Prostate Problems	Taking Birth Control
Diabetes	Menstrual Problems	Numbness in Groin/Buttocks
High Blood Pressure	Urinary Problems	Seizures/Epilepsy
Stroke	Current Pregnant, # weeks_____	
Dizziness/Fainting	Abnormal Weight Gain Loss	
Corticosteroid Use	Marked Morning Pain/Stiffness	
Osteoporosis	Visual Problems	
Pain at Night		

Cancer/Tumor Explain:_____

Other health problems: _____

List any medications and why you are taking each one (including over-the-counter)

_____

_____

Have you ever had any surgeries or have been hospitalized? Yes No

If so, when and what for? _____

_____

Please list all accidents and injuries you've had, including in your childhood: (include dates)

_____

_____

FAMILY HISTORY: (Please circle all that apply)

Cancer Diabetes High Blood Pressure Stroke/Heart Problems Rheumatoid Arthritis

Other:_____

Health is affected by your nervous system but it is also affected by your environment, the foods you consume, and your overall lifestyle activities and habits. Chiropractic care is an important addition yo a healthier lifestyle but it requires **TIME** to all your body to heal

****We ask that you commit to your required visits to achieve your overall health goals received in this office****

I understand the above information and guarantee this form was completely correctly to the best of my knowledge. I also understand it is my responsibility to inform this office of any changes in my medical status.

Patient Signature:_____ Date:_____

Guardian's Name (If patient is a minor):_____ Relationship: _____

Name of Patient :_____

Guardian Signature (If patient is a minor):_____ Date:_____

X-RAY CONSENT FORM

I authorize the performance of diagnostic x-ray examination of myself that may be considered necessary and advisable in the course of my examination and treatment at Vital Chiropractic Clinic PLLC.

Patient Signature_____ Date_____

If patient is a Minor

I am the parent or legal representative of _____ who is a minor, _____ years of age. I authorize the performance of diagnostic x-ray of this minor which Vital Chiropractic Clinic may consider necessary or advisable.

Parent/Guardian Signature _____ Date_____

Females: Regarding Possibility of Pregnancy

This is to certify that, to the best of my knowledge, I am not pregnant, and Vital Chiropractic Clinic has my permission to perform diagnostic x-ray examination. I have been advised that certain x-ray examinations, particularly those involving the pelvis, can be hazardous to an unborn child.

LAST DAY OF YOUR LAST MENSTRUAL CYCLE:_____

Patient Signature_____ Date_____

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA) Consent Form

Release of Information: Your Protected Health Information (PHI) will be used by this office and/or discussed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations in this office. You should review the Notice of Privacy Practices for a more complete description of how your PHI may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk. This office reserves the right to modify the Privacy Practices outline in the Notice.

Requesting a Restriction on the Use of Disclosure of Your information: You may request a restriction on the use or disclosure of your PHI. It is the policy of this office that it will continue to provide treatment for a patient who restricts consent to the use and disclosure of his/her PHI for the purposes of treatment, payment, or health care operations. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards. The office premises are monitored via surveillance cameras strictly for security purposes.

Revocation of Consent: You may revoke this consent to the use and disclosure of PHI. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

I,_____(print) acknowledge that I have reviewed the above information and I authorize this office to release information concerning my condition and treatment to my insurance company, attorney, insurance adjuster and/or other health care providers deemed necessary for treatment. I do understand that if I choose to refuse release of this information, that my PHI will be used switching the office for purposes of my care, to those individuals designated by the doctor, I acknowledge that there are surveillance recordings throughout the office for security purposes.

Patient or Guardian Signature:_____ Date:_____

INFORMED CONSENT TO CHIROPRACTIC CARE

We provide adjustments or manual manipulations through the gentle application of a targeted movement where and when indicated by the licensed Doctor of Chiropractic to improve motion of the body's spinal column and extremities.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi- disciplinary studies conducted over many years and has been demonstrated to be an effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Routine chiropractic treatment can result in better function, improved joint motion, and a healthier, more active lifestyle.

However, there are some risks associated with chiropractic adjustments, including but not limited to the possibility of sprains, dislocations and fractures. In addition:

1. While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques.

2. There are reported cases of stroke associated with neck movements including adjustments of the upper cervical spine. Current medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because a stroke may cause serious neurological impairment and result in injuries including paralysis.

3. There are reported cases of disc injuries following cervical and lumbar spinal adjustments or chiropractic treatment.

The risk of injuries or complications from chiropractic treatments are substantially lower than that associated with many medical other treatments, medications and surgical procedures given for the same treatments.

Common alternatives to adjustments and manipulations include medications, physical therapy, other medical treatments and surgery provided by physicians and surgeons.

By signing this informed consent, I acknowledge that I have discussed, or have had the opportunity to discuss, with my Doctor of Chiropractic the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustments), the benefits, risks and alternatives to chiropractic treatment.

I consent to the chiropractic treatments offered or recommended to me by my Doctor of Chiropractic, including spinal adjustments. I intend this consent to apply to all my present and future chiropractic care received from Vital Chiropractic Clinic PLLC.

I understand and am informed that some risks are associated with chiropractic adjustments, including, but not limited to sprains, dislocations, fractures, disc injuries, stroked and paralysis.

Patient Name_____

Patient Signature_____ Date_____

Name of Doctor _____

Doctor Signature _____ Date_____

Parental Consent for Minor *only*:

Patient Name:_____ Patient Date of Birth:_____

Printed name of person authorized to sign for Patient:_____

Parent/Guardian Signature:_____