Informed Consent

We encourage and support a shared decision making process between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. Vertebral subluxation is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the reduction of nerve interference caused by vertebral subluxations.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation and radiological examination (x-rays). If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different motions or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. In addition there are reported cases of stroke associates with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic care and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

ALL QUESTIONS REGARDING THE DOCTOR'S OBJECTIVE PERTAINING TO MY CARE IN THIS OFFICE HAVE BEEN ANSWERED TO MY COMPLETE SATISFACTION. THE BENEFITS, RISKS AND ALTERNATIVES OF CHIROPRACTIC CARE HAVE BEEN EXPLAINED TO ME TO MY SATISFACTION. I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS AND THERFORE ACCEPT CHIROPRACTIC CARE ON THIS BASIS.

Print Name Signature Date

Consent to evaluate and adjust a minor child:

I, _____, being the parent or legal guardian of _____, have read and fully understand the above Informed Consent and herby grant permission for my child to receive chiropractic care.

Health Care Authorization

The notice of Privacy Practices describes the type of uses and disclosures of my Protected Health Information (PHI) that will occur in my treatment, payment of my bills or in the performance of health care operations of this chiropractic office. I have been made aware of my ability to obtain a copy of the full HIPAA Notice from the front desk and we encourage you to read it and request your own copy if you would like one. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

I hereby give permission to Infinite Life Chiropractic Center to use and/or disclose Protected Health Information in accordance with the following:

- ❖ I give permission to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information.
- ❖ If Infinite Life Chiropractic Center contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.
- ❖ I give permission to use my name on a welcome board, referral board, and birthday board.
- ❖ I give permission to use my photograph on their patient picture bulletin board and other marketing materials such as their brochure, website and ads in print media.
- ❖ I give permission to use any testimonial written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochure, on their website or in ads in print media.
- ❖ I give permission to treat me in a closed room where other patients will be nearby. I am aware that other persons in the office may overhear some of my protected health information during the course of care.
- ❖ By signing this form you are giving permission to use and disclose your protected health information in accordance with the directives listed above.

This authorization will remain in effect for the duration of my care at Infinite Life Chiropractic Center plus 7 years or until revoked by me.

RIGHT TO REVOKE AUTHORIZATION: You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization. Please contact the office for correct procedures in revoking authorization.

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, Infinite Life Chiropractic Center will not refuse to provide treatment however, it will not be possible for them to file third party billing on my behalf and I will be responsible for 1) payment in full at the time services are provided to me 2) scheduling my own appointments since they will be unable to contact me 3) all contact with us regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.* I have the right to inspect or copy, within boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

Print Name Signature Date

Consent to the above for a minor child:

I, _____, being the parent or legal guardian of _____, have read and fully understand the above Health Care Authorization and herby grant permission for my child to receive chiropractic care.

Office Use Only:
ID #:
By:

Today's Date:_____

Adolescent Intake Form

Personal Information

Name: Age: Sex:

What do your child prefers to be called: Date of Birth: / /

Address: City: State: Zip:

Names and Ages of Siblings:

Parent A	Parent B
Name:	Name:
Home Phone:	Home Phone:
Cell Phone:	Cell Phone
E-mail Address:	E-mail Address:
Date of Birth:	Date of Birth:

Who do you prefer we contact for confirming appointments? Parent A or Parent B

How do you prefer we contact for confirming appointments? E-mail or Text

Emergency Contact: Relation to You: Phone Number:

Who may we thank for referring you to our office?

Reason for Seeking Chiropractic Care

What is your reason for bringing your child in today:

How is this affecting your quality of life? Please circle all those that apply.

School Attention/Focus Sleep Exercise/Sports

Playing Walking Communication Eating

Family Time Other: _____

Rate the amount this is affecting your child's life: (mild) 1 2 3 4 5 6 7 8 9 10 (severe)

How did this start? When did this begin?

Has your child ever had this previously? When?

Did this begin during: ☐School ☐Sports/Play ☐Auto Accident ☐Routine/Household Activity ☐Randomly

Health Care Practitioner History

Have you consulted or do you regularly consult any of the following providers?

Medical Physician Naturopath Acupuncturist Homeopath

Massage Therapist Dentist Energy Healer Psychotherapist

Name of Pediatrician/Family MD:

Has your child ever received Chiropractic Care? With whom:

How long under care: Date of Last visit:

Why did you stop care?

Subluxation Causes

Chiropractors are specialists of the spine and nervous system and focus on locating, analyzing and correcting vertebral subluxations. A vertebral subluxation occurs when a spinal bone is displaced from its normal alignment resulting in dysfunction of the nervous system. Subluxations are caused due to three reasons: Traumas, Thoughts and Toxins. The information below gives us a better understanding of what may be causing your subluxations and helps us know the best way to care for you.

Pregnancy & Birth

The pregnancy and birth process can be very traumatic on a baby's spine and may result in subluxations. Please answer the following questions to the best of your ability because they give great insight to what your child may be experiencing.

During pregnancy, did the mother:

□ Experience any significant illnesses, difficulties, or trauma?

□ Take any drugs/medications?

□ Smoke or consume alcohol

Name of Obstruction/Midwife:

Circle which best describes the type of birth: Home Birth | Hospital Birth | Vaginal | Water Birth | Caesarean

Was the delivery premature? □ No □Yes Weeks: Weight:

Approximately how long did labor last? Hours

Was labor artificially induced? □ No □ Yes

Third Trimester Presentation: □ Vertex (head down) □ Breech □ Transverse □ Face/Brow

Circle if any of the following were used or administered during labor and birth:

Epidural Pitocin Vacuum Forceps Episiotomy Suction Cap or Vacuum

Circle all that apply to the baby's status immediately after birth:

Jaundice (Yellow) Feeding Problems Displaced Joints Respiratory Problems Cyanosis (Blue)

Broken Bones: Other conditions:

What was the APGAR Score?

Infant Feeding: □ Breast □ Bottle, if bottle, which formula?

Physical Traumas

Physical traumas, such as falls, accidents and surgeries may result in decreased function of your nervous system due to the physical shift of the vertebra resulting in pressure on the nerves exiting the spine.

List any surgeries with dates:

List any broken bones with dates:

List any hospitalizations with dates:

Other physical traumas:

Does your child exercise: If so, how often:

Type of exercise:

How many hours of sleep per night? Quality of Sleep: □ Good □ Fair □ Poor

Emotional Thoughts

The way that we think about ourselves and deal with stress affects the way that our body heals. It can be difficult to identify emotion stress in children but it still has an effect on their bodies.

Circle if your child has ever or is currently experiencing any of the following emotion stresses:

Academic pressure Loss of a loved one Bullying New sibling

Lifestyle change Parents' divorce Relocation Loss of pet

Does your child have difficult interacting with schoolmates or friends? □ Yes □ No

Have you noticed that your child is nervous, twitches, shakes or exhibits rocking behavior? □ Yes □ No

Chemical Toxins

The substances that we eat, breathe and smell all affect the way that our body heals and also the function of our nervous system. Any substance that the body does not recognize as natural puts a stress on the system, resulting in the nervous system functioning lower than it should.

List all current medications:

List any vitamins/ supplements your child is taking:

Have you chosen to vaccinate your child? □ No □ Yes

If yes, please list all vaccination your child has received and at what age they were administered:

Please describe any and all reactions to vaccine(s):

Is the child exposed to second hand smoke?

Is the child allergic to anything? If so, please list:

Does the child follow a special dietary regimen? If yes, explain:

Health History

Does your child currently or has your child previously had any of the following diseases, medical conditions or procedures? **Please mark a P for Past, C for Currently and N for Never.**

Headaches	Orthopedic Problems	Digestive Disorders
Dizziness	Neck Problems	Poor Appetite
Fainting	Arm Problems	Stomach Aches
Seizures/Convulsions	Leg Problems	Reflux
Heart Trouble	Joint Problems	Constipation
Chronic Earaches	Backaches	Diarrhea
Sinus Troubles	Poor Posture	Diabetes
Asthma	Scoliosis	Hypertension
Colds/Flu	Walking Trouble	Anemia
Colic	Broken Bones	Bedwetting
Behavioral Problems	Ruptures/Hernia	Allergies to:
ADD/ADHD	Muscle Pain	Allergies to:
	Growing Pain	Other:

Authorization

I hereby authorize Infinite Life Chiropractic Center and its Doctor to administer care as they so deem necessary to my son/daughter/ward (upon approval of parent or guardian).

Child's Name Printed Here

Date

Parent or Legal Guardian's Name (Printed):

Signature:

Financial Policy

**I understand that I am responsible for all fees charged at Infinite Life Chiropractic Center.
**I agree to pay for all services provided at the time of service.

Child's Name Printed Here _____ Date _____

Parent or Legal Guardian's Name (Printed): _____ Signature: _____

Late Arrival & Cancellation Policy

** Arriving to your child's appointment at Infinite Life Chiropractic on time is important for reaching and maintaining the desired health goals and for the office flow. Dr. Liz tries her best to respect your time by maintaining the schedule to the best of her ability and she asks that you also respect her time by showing up for your appointments on time and ready to be seen.

** We understand that a situation may arise that could force you to reschedule, postpone or cancel your appointment. ILCC will reschedule your appointment ONE TIME at no change. Beyond that, if you show up for your appointment seven (7) minutes late, you will be charged 25% of your appointment fee. If you do not show up to your appointment, you will be changed 75% of your appointment fee due prior to your next appointment being scheduled. If you need to reschedule, kindly give us at least 24 hours notice.

** Thank you for allowing us the privilege of serving you and your family in your chiropractic needs!

** I understand and will follow the above policy and commit to maintaining our agreed upon scheduled appointments.

Child's Name Printed Here _____ Date _____

Parent or Legal Guardian's Name (Printed): _____ Signature: _____

Authorization to Treat without Parent Present

** I give permission for my son/daughter/ward to receive care without my presence in the office at time of treatment **

Child's Name Printed Here _____ Date _____

Parent or Legal Guardian's Name (Printed): _____ Signature: _____