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:

Adult Intake Form

Personal Information

Name: Age:

What do you prefer to be called: Date of Birth: / /

Address: City: State: Zip:

Phone: Home: Cell: Work:

E-mail Address:

How do you prefer we contact you when confirming appointments? E-mail and/or Text

Occupation: Employer:

Employer's Address: City: State: Zip:

Emergency Contact: Relation to You: Phone:

Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Names and Ages of Children:

Who may we thank for referring you to our office?

Reason for Seeking Chiropractic Care

What is your reason for coming in today:

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

Work	Driving	Sleep	Exercise/Sports
School	Walking	Sitting	Eating
Family Time	Other:		

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

How did this start? When did this begin?

Have you ever had this previously? When?

Did this begin during: ☐Work ☐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

Reason why:

Have you ever received Chiropractic Care? With whom:

How long under care: Date of Last visit:

Why did you stop?

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.

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:

Do you exercise: If so, how often:

Type of exercise:

Emotional Thoughts

The way that we think about ourselves and deal with stress affects the way that our body heals. When you are in a relaxed state your body is able to heal itself from daily stresses, but when you experience high stress levels, your body only focuses on the stress, not healing.

What is your daily stress level: (Circle one) Low 1 2 3 4 5 6 7 8 9 10 High

What is your major stressor:

How would you grade your emotional health: ☐Good ☐ Fair ☐Poor

How do you rate your overall quality of life: ☐Good ☐Fair ☐Poor

How many hours of sleep do you get on an average night?

What is the quality of that sleep: ☐Good ☐Fair ☐Poor

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 you are taking:

Please describe your diet:

Do you consume any of the following presently?

☐Coffee/caffeine ☐Alcohol ☐Tobacco How often/much:

Are you allergic to anything? If so, please list:

Do you follow a special dietary regimen? If yes, explain:

For Women

Are you pregnant? Date of last menstrual period:

If pregnant, due date: Name of OB/GYN or Midwife:

Where will you be birthing your baby? ☐Home ☐Hospital ☐Birthing Center ☐Other:

If over the age of 45: date of last mammogram:

Health History

Do you currently or have you in the past had any of the following diseases, medical conditions or procedures?

Please mark a P for Past, C for Currently and N for Never.

Dizziness	Numbness in Arms	Leg/Knee Pain
Headache	Numbness in Hands	Liver Disease
Vertigo	Menstrual Disorder	Shoulder Pain
Ear infections	Heart Disorders	Chronic Fatigue
Nausea	Stomach Disorders	Lupus
TMJ	Kidney Problems	Fibromyalgia
Neck Pain	Mid Back Pain	Chest Pain
Migraines	Irritable Bowel	Arm Pain
Anxiety	Sciatica	ADD/ADHD
Throat Issues	Numbness in Legs	Bladder Problems
Thyroid Problems	Numbness in Feet	Epilepsy
Asthma	Low back Pain	Infertility
Chronic Sinus Issues	Hip Pain	Other:

Authorization

**I hereby authorize Infinite Life Chiropractic and its Doctor to administer care as they so deem necessary

Print your name here _____ Date _____

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.

Print your name here _____ Date _____

Signature _____

Late Arrival & Cancellation Policy

** Arriving to your 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

Print your name here _____ Date _____

Signature _____