Family Chiropractic Center, Inc.
Optimal Health Center, LLC
4201 Bee Cave Road
Suite C212
Austin, Texas 78746
(512) 347-8033
www.famchiro.com

We want to welcome you to the Family Chiropractic Center and Optimal Health Center.

Our goal is to provide for your health needs through the use of modern chiropractic and natural health techniques. We look forward to serving you.

Our office is located in the Schoolyard, an office park just west of Eanes Elementary School on Bee Cave Road. Suite C212 is in Building C, at the back of the complex.

Please arrive wearing comfortable, loose-fitting clothing and allow up to 90 minutes for your initial appointment.

Attached you will find a “Patient History”. Please print and complete it. This will allow us to focus your examination on the matters of maximum importance to you. Bring your history along with a photo ID and your insurance card to your first visit.

An acknowledgment of our “Privacy Policies & Consents” is included at the end of the history. A complete version of these policies is either included as a separate file or is available on our website. Please review the complete document prior to signing the acknowledgement.

If you have any questions prior to your appointment, please call or email info@famchiro.com.

Supporting your well being,

Your Doctors and Staff

CONFIDENTIAL INFORMATION

We appreciate the opportunity to support you in meeting your desired health outcomes. Please assist us by completing the following information.

Last Name First Name Nick Name

If Child Under 18: Mother's Name Father's Name

Street Address, City, State & Zip

Cell Phone Home Phone Work Phone

Email DOB Age Marital Status M S W D

Occupation Partner's Name:

Names & Ages of Children

Emergency Contact Relationship Phone

Preferred Communication: Text / Email / Phone Health Insurance Co.:

How Did You First Hear About Our Office?: ☐ Friend ☐ Website ☐ Google ☐ Yelp ☐ Other Social Media

Who May We Thank For Referring You To Our Office?

Height: ft in Current Weight: Weight One Year Ago:

How Would You Rate Your Current Overall Health? /10 What Would You Like Your Health To Be? /10

Health Goals: People consult our office with one or more health objectives.

Please indicate the outcomes you desire from your care in our office.

☐ Wellness Care ☐ Get my health back and maintain optimal health

☐ Relief of current symptoms ☐ Minimal activity limitations ☐ No activity limitations

☐ Correction of underlying health problems ☐ Learn exercises or other things I can do to help myself

Signature: _____ Date: _____

YOUR HEALTH HISTORY

Life is a journey. Your health status is a result of many factors and experiences you have had along the way. To best assess how we may help you, we are interested in events and stressors that may have played a part through your formative years as well as current factors.

Pre-Pregnancy

Did your parents…	Yes	No	Unsure
Plan and welcome the pregnancy?	☐	☐	☐
Prepare their bodies for conception and pregnancy?	☐	☐	☐

Pregnancy

Did your mother…	Yes	No	Unsure
Have chiropractic care during pregnancy?	☐	☐	☐
Exercise through pregnancy?	☐	☐	☐
Have a nutritious diet during pregnancy?	☐	☐	☐
Have any significant injury during pregnancy?	☐	☐	☐
Smoke, drink alcohol or take drugs during pregnancy?	☐	☐	☐
Have any significant stress during pregnancy?	☐	☐	☐

Birth Process

Was your birth…	Yes	No	Unsure
Home birth or at birthing center?	☐	☐	☐
Hospital birth?	☐	☐	☐
Early or late according to due date?	☐	☐	☐
Induced labor?	☐	☐	☐
Involving drugs during delivery?	☐	☐	☐
A long or difficult delivery?	☐	☐	☐
Caesarean delivery?	☐	☐	☐

Physical Development	Yes	No	Unsure
Have you experienced…			
Physical abuse by siblings or others?	☐	☐	☐
Being violently pulled by your arm as a child?	☐	☐	☐
Self abuse: head-banging, cutting, etc.?	☐	☐	☐
Get hit or fall on your head?	☐	☐	☐
Have a major fall, as in down stairs?	☐	☐	☐
Auto accident or other trauma?	☐	☐	☐
Sports injuries?	☐	☐	☐

Chemical Exposure	Yes	No	Unsure
Were you breast fed? If so, how long? _____ months	☐	☐	☐
Were you bottle fed? If so, how long? _____ months	☐	☐	☐
Were you vaccinated?	☐	☐	☐
Were you mainly fed nutritious home-cooked meals from fresh ingredients?	☐	☐	☐
Were you mainly fed processed convenience foods and fast foods?	☐	☐	☐
Did you mainly drink filtered or purified water vs tap water?	☐	☐	☐
Did you mainly drink sodas or sugary tea, etc.?	☐	☐	☐

Mental / Emotional Stress	Yes	No	Unsure
Was there communication breakdown in your childhood home?	☐	☐	☐
Was there the loss of a parent or close relative	☐	☐	☐
Was there ongoing stress in your family?	☐	☐	☐

Please provide details of above or other stresses you experienced.

_____

Family Medical: Please note any significant family medical history. _____

_____

_____

Have you experienced a loss in the last 5 years? (e.g. relationship, family, business, financial) Y N (If yes, please describe)

_____

Any significant current stresses? ☐ Home ☐ Work ☐ Family ☐ Financial _____

_____

Food Allergies: ☐ Gluten ☐ Dairy ☐ Other: _____

Lifestyle	Yes	No	Unsure
Do you smoke?	☐	☐	☐
Do you drink alcohol?	☐	☐	☐
Do you stay well hydrated?	☐	☐	☐
Do you mainly eat nutritious home-cooked meals from fresh ingredients?	☐	☐	☐
Do you exercise regularly?	☐	☐	☐
Do you sleep well?	☐	☐	☐
Are your teeth healthy?	☐	☐	☐
Are you mentally stressed?	☐	☐	☐
Is 'screen time' a major part of your day?	☐	☐	☐
Do you frequently sit for hours at a time? How many hours sitting a day? _____	☐	☐	☐

Do you crave sweets and regularly eat candy or sugary foods? Y N Do you use artificial sweeteners? Y N

Current Sports: _____

Injuries: _____

Surgeries: _____

Current Medications: _____

Supplements: _____

Do You Use: ☐ Orthotics ☐ Shoe Lift ☐ Back Brace ☐ Other Support _____

Reason For Seeking Care Now: ☐ Wellness Care (Skip to the Next Page)

☐ Treatment of Health Concerns (Provide Details)

Primary Concern: _____ Severity: ____/10 % of Time Noticed ____%

Began: _____ Event: _____

Sensation: ☐ Sharp ☐ Burning ☐ Dull ☐ Ache ☐ Sore ☐ Stiff ☐ Spasm ☐ Numb ☐ Radiates to _____

Progression: ☐ Getting Worse ☐ Getting Better ☐ Not Changing ☐ Previous Episodes? Y N _____

Worse When You: ☐ Sit ☐ Stand ☐ Walk ☐ Lift ☐ Exercise ☐ Drive _____

Improves With: ☐ Rest ☐ Lying Down ☐ Massage ☐ Cold ☐ Heat ☐ Meds _____

Recent Medical Care or Other Treatment: _____

_____

_____

Previous Chiropractic Care Y / N Last Visit: _____

What type of care did they provide?

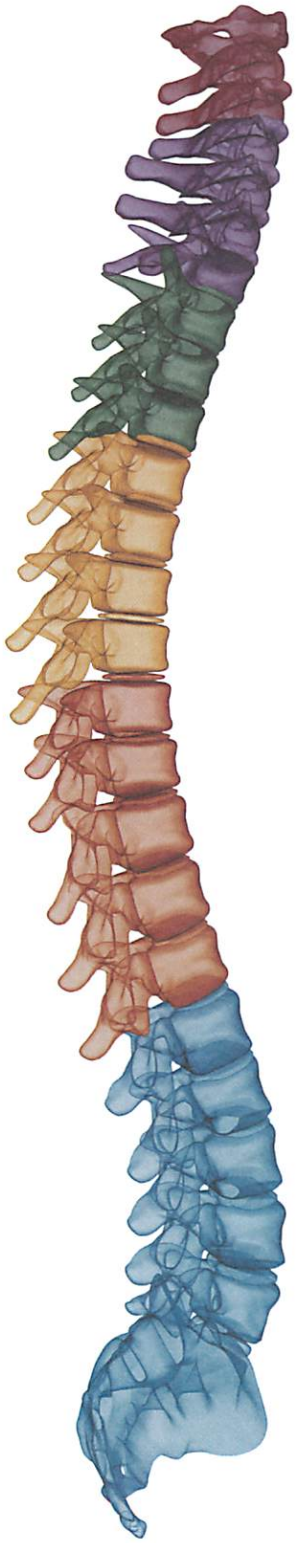
☐ 'Limited Scope' Chiropractor (Focuses mainly on neck and back pain)

☐ 'Optimal Health' Chiropractor (Focuses on optimal health & underlying causes of pain and health concerns)

Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present.



REGIONS	FUNCTIONS	SYMPTOMS			
		PAST	PRESENT		PAST PRESENT
Cervical	• Autonomic Nervous System • ENT System • Vision, Balance & Coordination • Speech • Immune System • Digestive System • Nerve Supply to Shoulders, Arms & Hands • Sympathetic Nucleus • Metabolism	☐	☐	Colic & Excessive Crying	☐ ☐ Epilepsy & Seizures
		☐	☐	Ear & Sinus Infections	☐ ☐ Sensory & Spectrum
		☐	☐	Allergies & Congestion	☐ ☐ ADD / ADHD
		☐	☐	Immune Deficiency	☐ ☐ Focus & Memory Issues
		☐	☐	Headaches & Migraines	☐ ☐ Anxiety & Stress
		☐	☐	Vertigo & Dizziness	☐ ☐ Balance & Coordination
		☐	☐	Sore Throat & Strep	☐ ☐ Speech Issues
		☐	☐	Swollen Tonsils & Adenoids	☐ ☐ TMJ / Jaw Pain
		☐	☐	Vision & Hearing Issues	☐ ☐ Stiff Neck & Shoulders
		☐	☐	Low Energy & Fatigue	☐ ☐ Depression
		☐	☐	Difficulty Sleeping	☐ ☐ High Blood Pressure
		☐	☐	Pain, Numbness & Tingling in Arms to Hands	☐ ☐ Poor Metabolism & Weight Control
Upper Thoracic	• Upper G.I. • Respiratory System • Cardiac Function	☐	☐	Reflux / GERD	☐ ☐ Bronchitis & Pneumonia
		☐	☐	Chronic Colds & Cough	☐ ☐ Functional Heart Conditions
		☐	☐	Asthma	
Mid Thoracic	• Major Digestive Center • Detox & Immunity	☐	☐	Gallbladder Pain / Issues	☐ ☐ Indigestion & Heartburn
		☐	☐	Jaundice	☐ ☐ Stomach Pains & Ulcers
		☐	☐	Fever	☐ ☐ Blood Sugar Problems
Lower Thoracic	• Stress Response • Filtration & Elimination • Gut & Digestion • Hormonal Control	☐	☐	Behavior Issues	☐ ☐ Allergies & Eczema
		☐	☐	Hyperactivity	☐ ☐ Skin Conditions / Rash
		☐	☐	Chronic Fatigue	☐ ☐ Kidney Problems
		☐	☐	Chronic Stress	☐ ☐ Gas Pain & Bloating
Lumbar, Sacrum & Pelvis	• Lower G.I. (Absorption & Motility) • Gut-Immune System • Major Hormonal Control	☐	☐	Constipation	☐ ☐ Sciatica & Radiating Pain
		☐	☐	Crohn's, Colitis & IBS	☐ ☐ Lumbopelvic / SI Joint Pain
		☐	☐	Diarrhea	☐ ☐ Hamstring Tightness
		☐	☐	Bed-wetting	☐ ☐ Disc Degeneration
		☐	☐	Bladder & Urination Issues	☐ ☐ Leg Weakness & Cramps
		☐	☐	Cramps & Menstrual Issues	☐ ☐ Poor Circulation & Cold Feet
		☐	☐	Cysts & Endometriosis	☐ ☐ Knee, Ankle & Foot Pain
		☐	☐	Infertility	☐ ☐ Weak Ankles & Arches
		☐	☐	Impotency	☐ ☐ Lower Back Pain
		☐	☐	Hemorrhoids	☐ ☐ Gluten & Casein Intolerance

Patient Name: _____ Date: ___/___/___

Family Chiropractic Center, Inc. / Optimal Health Center, LLC
Acknowledgement for Use and Disclosure of Protected Health Information and Consents to Evaluation, Treatment and Financial Policies

Notice of Privacy Practices I have read and understand the Family Chiropractic Center, Inc. / Optimal Health Center, LLC Notice of Privacy Practices; ***"Your Information. Your Rights. Our Responsibilities"*** as well as "Informed Consents" which describe how my Protected Health Information (PHI) may be used or disclosed. I understand that I may request a copy of the Notice at the Front Desk or view it at our website, www.famchiro.com

Informed Consent and Authorization for Chiropractic Evaluation and Treatment: I understand that although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, there are possible risks and complications associated with these procedures. I have read and understood the description of common risks associated with these procedures. I hereby authorize the doctors of FCC / OHC to perform the history, diagnostic and examination procedures they deem necessary related to conditions presented in this office.

I understand that the doctors have the right to refuse or accept me as a patient at any time before treatment begins. Should they accept me for treatment, I give my consent to the performance of conservative, noninvasive treatment to the joints and soft tissues. I understand that chiropractic procedures may consist of adjustments involving movement of the joints and soft tissues. Adjunctive physical therapy, exercises and nutritional therapy may also be used in my treatment. I understand that there may be additional risks associated with any of these forms of treatment. Should I have any adverse reactions to treatment, I will notify my doctor as soon as possible. I intend this consent to apply to all present and future chiropractic care received in this office.

Non-Covered Services Policy: I understand that insurance companies will not cover a portion of the services or supplies I receive at this office for reimbursement. I will be informed in advance of these items. They will not be billed to my insurance company and will be my sole financial responsibility. The following is a partial list of these services and their standard fees at the time of this notice:

Insight Neuro-diagnostic Scan Suite	$ 45
Neuro-Muscular Reflex Examination	$ 45
Muscle Priority Assessment	$ 20
Optimal Health / Wellness Visit	$ 75
Nutritional Supplements / Supplies	Varies

Informed Consent of Appointment Scheduling Policies If I discover that I am not able to make a scheduled appointment, I will notify this office at the earliest possible opportunity. **I understand that if I miss an appointment or fail to provide twenty-four hours notice prior to cancelling or rescheduling an appointment, I will be responsible for paying for that appointment in full.**

Authorization for Direct Payment to Family Chiropractic Center, Inc. Should I have an outstanding balance on my account with Family Chiropractic Center, Inc., I authorize direct payment of my medical benefits to Family Chiropractic Center, Inc. for the health care services rendered to me. I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that I am personally responsible for these services should they not be covered by insurance.

Signature
I have reviewed and agree with this consent form. I also give my permission to this office to use and disclose my health information in accordance with the described Protected Health Information Policies.

_____ _____ _____
Name of Patient (print) **Signature of Patient (Or Patient Parent/Representative)** **Date**

_____ _____
Office Representative **Date**

Direct Questions to Privacy Official:
Leila McDonald
info@famchiro.com
(512) 347-8033

Revised December 31, 2019

Family Chiropractic Center, Inc.
Optimal Health Center, LLC

Privacy Officer: *Leila McDonald*
(512) 347-8033
info@famchiro.com

Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

continued on next page

Your Rights *continued*

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
  - We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
  - We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

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How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

We do not create or maintain psychotherapy notes in our practice.

As a service to our Practice Members we provide appointment confirmation messages via voicemail, text or email. There are also occasions when these communication modes will be used for such purposes as sending you information about your care or to inquire about your condition. These electronic communication tools will not be used for highly sensitive or confidential information. It is important to realize however that these communications are not completely secure from interception. If you prefer that we only contact you via phone, mail or fax please let us know.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date: 12/31/2019

This Notice of Privacy Practices applies to the following organizations.

Family Chiropractic Center, Inc.
Optimal Health Center, LLC

Privacy Official: Leila McDonald (512) 347-8033 info@famchiro.com

Informed Consents

Family Chiropractic Center, Inc.
Optimal Health Center, LLC

This Notice Describes Our Policies And Consents Regarding Examination, Treatment, Financial Responsibility And Appointment Scheduling.

1. Informed Consent to Chiropractic Evaluation and Treatment

Chiropractic treatments, including spinal adjustments, have been the subject of government reports and multi-disciplinary studies conducted over many years and have been demonstrated to be highly effective treatment for conditions causing spinal pain, headaches, and various other symptoms. Chiropractic care contributes to your overall well-being. *The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.*

Although the spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, we want to inform you there are possible risks and complications associated with these procedures as follows:

a) Like exercise, it is common to experience muscle soreness following the first few treatments.

b) While rare, some patients have experienced rib fractures, muscle strains and/or ligament sprains following spinal adjustments. In isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, we will proceed with extra caution.

c) Disc injuries have also been reported occasionally. No scientific study has ever demonstrated however that such conditions are caused by chiropractic adjustments.

d) Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. Nerve or brain damage including stroke is reported to occur once in one million to once in ten million chiropractic treatments.

2. Informed Consent to Appointment Scheduling Policies

We will schedule appointments based on anticipated needs of the visit.

Should you have a new injury or condition, we request that you communicate this to receptionist in advance of your appointment to allow for adequately scheduled time to care for your needs.

If you discover that you are not able to make a scheduled appointment, please notify our office at the earliest possible opportunity, so that this time can be made available to other patients. **If you miss an appointment or fail to provide twenty-four hours notice prior to cancelling or rescheduling an appointment, you will be responsible for paying for that appointment in full, as missed appointment fees are not covered by my insurance.**

3. Informed Consent to Communication Practices

We utilize email and text to schedule and confirm appointments. We will occasionally use the voicemail features of your telephone to leave messages for you. We will not use these means of communication for anything we believe is of a sensitive personal or clinical nature unless pre-approved by you. With your prior approval we will use these methods to communicate or send documents to you or to a person you designate.

4. Advance Beneficiary Notification of Non-Covered Services

Chiropractic care employs natural methods for the diagnosis and treatment of health conditions as well as for supporting optimal health states. Most people know chiropractic addresses structural or musculoskeletal problems of the back and neck. Yet it has a much greater range of effectiveness. Chiropractic adjustments interact and communicate with your nerve system, the control center for all the functions of your body. Chiropractic utilizes manual therapy with the intent of reducing nervous system stress and dysfunction. Our **Optimal Health Center** services also include health and lifestyle counseling, exercises and nutrition.

***Health Insurance Limitations*: Chiropractic services related to wellness or health maintenance are not covered by insurance. And, because some of our services are relatively new, health insurance policies term them 'investigational' or 'experimental' and do not cover them. We thus want to give you advance notice of the items that will not be billed to insurance and will remain your personal responsibility.**

Wellness, Maintenance and Supportive Care Services: Insurance policies cover chiropractic care related to the treatment of acute symptomatic conditions or acute exacerbations of chronic conditions. They specifically deny chiropractic reimbursement related to wellness or health maintenance. Nonetheless, periodic visits when you are not acutely ill permit us to identify and reduce dysfunction at an early stage. This care assists you in maintaining an optimum state of well-being and minimizes the onset of health problems. Since these services are not the result of a specific symptom or disease, insurance does not covered them.

Neuro-Muscular Reflex Assessment / Muscle Priority Analysis: An exceptional aspect of our chiropractic approach is the utilization of manual muscle testing for treatment priority determination. This means of assessing neurological function allows us to communicate with your nervous system via a form of 'manual biofeedback'. These sensory inputs to the nerve system thus alter function. In our office we specialize in this priority muscle testing, and it will be used in most of your visits. Since it is considered 'investigational', fees for this service will not be submitted to insurance.

Neuro-Diagnostic Scans: Locating and quantifying areas of neurologic stress is a key focus of our diagnostics. We utilize thermography, surface electromyography, heart rate variability and skin galvanic readings for initial assessment and progress examinations. Insurance companies do not currently cover this suite of tests. Thus, you will be personally responsible for the cost of these examinations.

Nutritional, Herbal and Homeopathic Therapy: There are a myriad of health problems that plague modern society due to poor nutrition and excessive environmental stress. Even if you pay reasonable attention to your lifestyle, you may still have problems resulting from these stressors. This complicates and slows the healing process. If we determine such is the case, we will utilize a variety of natural substances to support your healing and ongoing wellbeing. None of these tests or supplies are reimbursable by insurance.

Purification and Detoxification: We are exposed to external toxins everyday. These include pollutants, pesticides, and chemicals. Internally you produce waste byproducts as a result of normal metabolic function. Although your body is designed to rid itself of these toxins naturally, it can become overburdened. We offer purification programs to provide additional support to expel natural toxins and normalize your weight.

Functional Endocrinology: Your endocrine system is composed of a series of glands that release hormones. These chemical messengers communicate information to other tissues and cells, telling them how to respond. When this system is not working properly you will manifest problems such as fatigue, adrenal stress, thyroid or blood sugar imbalances and menopausal distress. We utilize laboratory tests and symptom survey instruments to evaluate your endocrine system. If imbalances exist we will recommend protocols of lifestyle changes, nutrition, herbs and bio-identical hormones.

This notice was published and becomes effective on December 31, 2019

Questions: Contact our Privacy Official

Leila McDonald
(512) 347-8033
info@famchiro.com