HEALING TOUCH CHIROPRACTIC

Dr. Michelle Kerr Patrick 1110 Hillcrest Rd, Ste 1-F, Mobile, AL 36695 251.289.1482

Initial ANA Evalutaion

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Home: _____ Cell: _____ Work: _____

Email: _____ Date of Birth: _____ Height: _____ Weight: _____

Referred By: __ Phyisician __ Friend/Family/Co-Worker __ Internet __ Other: _____

Please Attach: ____ Medications list ____ Copy of most recent blood work

Rate your energy levels (Best: 10 - Worst: 0):

____ Overall Energy ____ Morning ____ Afternoon ____ Activity Level ____ Exercise Level

WHAT MAIN HEALTH ISSUES DO YOU NEED HELP WITH?

Rate all that apply to you. (1 - Light 2- Moderate 3- Severe)

____ Low energy/fatigue
____ Weight
____ Pain: _____
____ Joint pain
____ Difffculty walking or moving
____ Blood pressure
____ Blood sugar
____ Chloesterol
____ Asthma, breathing diffculty
____ Allergies: _____
____ Allergies, sinues, respiratory
____ Skin rashes or breakouts
____ Itching or burning anywhere
____ Heart racing or palpitations
____ Sweling: _____
____ Frequent colds/flu/infections
____ Sleeping difficulty
____ Mood Swings
____ Aniexty/nervousness
____ Depression
____ Dizziness/vertigo
____ Hot flashes or night sweats
____ Focus/concentration/memory
____ Frequent urination/bladder leakage
____ PMS or menses (period) problems
____ Infertility problems
____ Learning diffculty/hyperactivity
____ Cold hands or feet
____ Erectile or prostate diffculty
____ Diarrhea ____ Constiaption ____ Gas
____ Bloating ____ Heartburn ____ Nausea
____ Other Not Listed: _____

What is youir #1 Main Health Concern?

_____

This information is correct, today I am receiving the services outlined in my Nutrition plan.

Patient Signature: _____ *Date:* _____

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Initial ANA Evaluation Report

Patient Name: _____ DATE: _____

Drainage/Balance	Immune Stressor	Recommended Programs
1. ____ Multizyme(3)	Food allergies	Avoid and Re-Introduce: ___ Corn
____ Zypan(3)	or sensivites	____ Wheat ___ Cow Milk ___ Soy
		____ Other: _____
2. ____ Parotid PMG(3-6)	Chemical toxicty	____ Chemical & lymphatic cleanse
	Lymphatic system drainage	
3. ____ Choalcol II(3-6)	Heavy metal toxicity	____ Heavy Metal Cleanse
4. ____ Spanish Black Radish(3)	Bad bacerial overgrowth	____ Weed & Feed Cleanse
5. ____ Garlic or Garlic Forte(2)	Parasite challenge	____ Parasite Cleanse
6. ____ Lact-Enz(3-6)	Yeast/Fungus overgrowth	____ Yeast Cleanse
7. ____ Antonex(3-9)____ Albizia(3)	Viral Challenges	____ Viral Cleanse/Immune Support
8. ____ Wheat Germ Oil Capsules(3)	Scars	Home Scar Therapy: ____ Oils
____ Sesame Seed Oil Capulse(3)		
9. ____ Cataplex ACP(6)	Low Immune System	____ Immune Stengthening
10.____ 21 Day Cleanse	Renew/Repair/Weight Loss	____ Whole Body Cleanse

Initial Weak Organs Reflex Points: _____

_____

____ First Supplement Protocol Explained (Phase 1 Preliminary Correcton)
____ Inital Supplements Purchased
____ Follow up visit scheduled in ____ 1 week or ____ 2 weeks
____ Pill Organizer Gift and Use Instruction
____ Food Journal & Avoid for 2 weeks: _____
____ Iodine Patch Test
____ Barnes Test Instructions Sheet Explained
____ HCL Sensitivity (Zypan)
____ Cleanse Programs Recommended (Correction Phase 2 & 3)

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ANA Body Points Initial Correction

Patient Name: _____ Date: _____

1. ___ Adrenal Glands: ___ Drenamin(6) ___ B6 Niacinimide(4) ___ Drenatrophin PMG(4) ___ Adrenal Complex(2) ___ Adrenal Dessicated(4)
2. ___ Bladder: ___ Albaplex(2) ___ Cataplex ACP(6) ___ Arginex(3)
3. ___ Bones: ___ Calcifood(6-12) ___ Cataplex C(3-6) ___ Biost(4-6) ___ Bone Complex(3) ___ Ostrophin PMG(4-6)
4. ___ Bowel: ___ Colax(1-2) ___ Spanish Black Radish(3) ___ Cholacol II(6) ___ Fen-Cho(4)
5. ___ Brain: ___ Neuroplex(3) ___ Neurtrophin PMG(4) ___ Pituitrophin PMG(4) ___ Min-Chex(3) ___ Hypothalmex(4) ___ Ribonucliec Acid(6) ___ Hypothalamus PMG(4)
6. ___ Bronchi: ___ Broncafect Tabs(4) ___ Broncafect Liquid (1 tsp in water PRN for coughing)
7. ___ Breasts: ___ Mammary PMG(4) ___ Spanish Black Radish(4)
8. ___ Eyes: ___ Iplex(4) ___ A-C Carbamide(4) ___ Bilberry Tabs(4) ___ Oculotrophin PMG(6)
9. ___ Ears: ___ Congaplex(6) ___ Echinacea(4) ___ Euphrasia(4) ___ Cataplex ACP(6) ___ Parotid PMG(4)
10. ___ Gall Bladder: ___ Choline(4) ___ AF Betafood(6) ___ Betafood(4) ___ Cholacol(4) ___ Phosfood(30-60 drops in full cup of water)
11. ___ Heart ___ Cardio-Plus(3-12) ___ Vasculin(3-9) ___ Cataplex G(4-6) ___ Cataplex E2(3-9) ___ Cardiotrophin PMG(3-6)
12. ___ Joints ___ Saligesic(4-6) ___ Boswelia(4-6) ___ Ligaplex(4-6) ___ Ligaplex II(4-6) ___ Cataplex C(3-6) ___ Bone Complex(3) ___ Ostrophin PMG(4-6)
13. ___ Kidneys ___ Renafood(4) ___ Arginex(4) ___ AC Carbamide(4-6) ___ Renatrophin PMG(4)
14. ___ Liver ___ Livaplex(3-6) ___ Livton(3) ___ Betacol(3-6) ___ AF Betafood (3-6) ___ Hepatrophin PMG(4-6)
15. ___ Lungs ___ Antronex(9) ___ CataplexAC/ACP(4) ___ Pneumotrophin PMG(6) ___ Emphaplex(4)
16. ___ Mucles** ___ Boswelia(3-6) ___ Ligaplex II(3-6) ___ Glucosamine(2+) ___ Myotrophin PMG(3-6) ___ Myo-Plus(3-6) ___ Calma Plus(3-6) ___ Cal. Lactate(6-12) ___ CataplexF Tab (3-6)
17. ___ Nerves** ___ Nevaton(4) ___ Neuroplex(4) ___ NeurotrphinPMG(4) ___ Cataplex G(4) ___ Cataplex B(2)
18. ___ Ovaries ♀ ___ Ovex(4) ___ Symplex F(4) ___ Wheat Germ Oil Perles (3) ___ OvatrophinPMG(3)
19. ___ Pancreas ___ Pancreatrophin PMG(6) ___ Zypan(3) ___ Gymnema(3) ___ Diaplex(6) ___ Cataplex GTF(6)
20. ___ Prosate ♂ ___ Orchic PMG(4) ___ Zinc Liver Che(4) ___ Prostate PMG(4) ___ Symplex M(4)
21. ___ Sinus ___ Fen-gre(3-6) ___ Euphrasia(3-6) ___ Allerplex(6) ___ Antronex(12) ___ Andrographis(3-6)
22. ___ Spleen ___ Spleen PMG(4) ___ Astragalus(2-4) ___ Spleen Dessicated(4)
23. ___ Stomach ___ Multizyme(3) ___ Zypan(3) ___ Okra Pepsin(3-6) ___ Betaine HCL(3) ___ HiPep(3-6)
24. ___ Small Intestines ___ OkraPepsin(3-6) ___ Dermatrophin PMG(3-6) ___ Chlorophyll Perles(3)
25. ___ Skin** ___ DermaCo(4) ___ Zinc Liver Che(4) ___ Cataplex E(6) ___ DermatrophinPMG(6) ___ Cyruta-Plus (Brusing,Bleeding)(4-6) ___ Chaste Tree (Acne, Femail w periods)(4)
26. ___ Scars** ___ RNA(3-6) ___ Sesame Seed OR Wheat Germ Oil Perles (topically & oral)(1-3)
27. ___ Thymus ___ Thymus PMG(3-6) ___ Thymex(3-6)
28. ___ Teeth/Jaw ___ Bio-Dent(4-6) ___ Congaplex (3-6) ___ Biost (4-6)
29. ___ Thyroid □ ___ Thytrophin PMG(2-4) ___ Prolaminelodine(3-6) ___ Thyroid Complex(2-4)
    ___ Thyroid □ ___ Thytrophin PMG(2-4) ___ Antronex(3-9) ___ Iodomere(3-6) ___ Parotid PMG(3-6)
30. ___ Uterus ♀ ___ Utrophin PMG(3-6) ___ Symplex F(3-6)

**Points are tested "anywhere"

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ANA Follow Up

Patient name: _____ Date: _____ Visit #:_____

1. How do you feel since your last visit?
   ____ Improved ____ No symptons
   ____ A little better ____ A lot better
   ____ A little worse ____ A lot worse
   ____ Some changes ____ No changes yet

1A. Check any that apply to you:
   ____ Took all supplements as listed
   ____ Took most of supplements
   ____ Did not take supplements
   ____ Did not get supplement/s

2. Have any symptoms improved or changed since your last visit? __No __Yes/Describe:
   Improvements: _____
   Changes: _____

3. Do You Have Any New Symptons or Issue? ____ No ____ Yes
   If Yes, Have You ____ Stopped a medication ____ Added a new medicaton
   ____ Had a medical or dental procedure ____ Got a Flu, Cold, Infection
   ____ Allergy ____ Injury ____ Overwork
   ____ Lack of sleep ____ Job change ____ Stress Related
   Describe: _____

4. RATE ENERGY CHANGES (Best: 10 – Worst: 0): 0 1 2 3 4 5 6 7 8 9 10
   Energy levels: ____ Overall ____ Morning ____ Afternoon
   ____ Activity level ____ Exercise level

5. RATE ALL SYMPTONS THAT APPLY (1-Mild 2-Moderate 3-Severe)

____ Low energy/fatigue	____ Sleeping difficulty
____ Weight	____ Mood Swings
____ Pain: _____	____ Anxiety/nervousness
____ Joint pain	____ Depression
____ Difficulty walking or moving	____ Dizziness/vertigo
____ Blood pressure	____ Hot flashes or night sweats
____ Blood sugar	____ Focus/concentration/memory
____ Cholesterol	____ Frequent urination/bladder leakage
____ Asthma, breathing diffculty	____ PMS or menses (period) problems
____ Allergies: _____	____ Infertility problems
____ Allergies, sinues, respiratory	____ Learning diffculty/hyperactivity
____ Skin rashes or breakouts	____ Cold hands or feet
____ Itching or burning anywhere	____ Erectile or prostate diffculty
____ Heart racing or palpitations	____ Diarrhea ____ Constipation ____ Gas
____ Swelling: _____	____ Bloating ____ Heartburn ____ Nausea
____ Frequent colds/flu/infections	____ Other Not Listed: _____

#1 MAIN SYMPTONS OF: _____

This information is correct, today I am receiving the services outlined in my Nutrition plan.

Patient Signature: _____ *Date:* _____

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909B Plantation Blvd, Fairhope, AL 36532 251.990.8188

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Subluxation (Vertebral or Extremity): A misalignment of one or more of the 24 vertebra in the spinal column or at an extremity joint which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

We do not offer to diagnose or treat any condition other than subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct subluxations of the vertebrae and extremity joints.

I, _____, have read and fully understand the above statements.
(print name of person completing form)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis. I consent to a professional and complete chiropractic examination, to any radiographic examination that the doctor deems necessary, and chiropractic treatment including adjustments.

For Patient's under 18 years of age:
I do hereby state that I have legal custody of the minor, _____. I grant my authorization and consent for the aforementioned minor to receive chiropractic services deemed necessary by Healing Touch Chiropractic.

_____

Patient or Legally Authorized Individual Signature Date

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Notice of Privacy Practices - Acknowledgement & Consent

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Healing Touch Chiropractic or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

I understand that, and consent to, the following appointment reminders or communications that will be used by this office: postcard mailed to me at my provided address, telephoning my home and leaving a message on my answering machine or with the individual answering the phone, texting my designated cell phone number; and/or emailing my designated email address. In addition, I give Healing Touch Chiropractic permission to sign me up for ChiroVoice.org.

Notice of Privacy Practices

You should review the Notice of Patient Privacy Policy that will be provided for a more complete description how your Protected Health Information 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. I acknowledge receipt of the 'Notice of Patient Privacy Policy.'

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Treatment Location

Note that some of your treatment may be performed in an 'open' area. Private areas are always available to discuss your health information upon request.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. 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.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature	Date
Print Patient's Full Name	Time
Witness Signature	Date

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Financial Policy & Chiropractic Active Life Plans

We, Healing Touch Chiropractic, are committed to providing you with the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal while maintaining compliance with various state and federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines. Our financial policies are as follows:

- Our clinic has established a single fee schedule that applies to all patients for each service provided.

- You will be expected to pay for your chiropractic care at the time service is rendered unless you arrange an Active Life Plan in advance.

- Active Life Plans include yearly Corrective Adjustment Plans (CAP), monthly CAPs, and extended payment plans. These Active Live Plans are designed to be the most cost-effective way to keep you and your family as healthy as possible. Details of these plans will be discussed with you during your Chiropractic Report of Findings.

- Health Insurance: If you have insurance that covers chiropractic, we will work with you to enable you to utilize all benefits under your plan. Our office will bill your insurance company directly and accept payments directly from it. If your insurance company does not pas as expected, all charges due will be your responsibility.

- You may be entitled to a network or contractual discount under the following circumstances:
    - If we are a participating provider in your health plan.
    - If you are covered by a State or Federal program with a mandated fee schedule.
    - If you have an established, current hardship discount through Victory Health Partners. Verification will be required.
    - If you are a member of Chiro Health USA, a Discount Medical Program, that we are a network provider of. Patients who are uninsured or underinsured (limited benefits for chiropractic care) will be entitled to network discounts similar to our insured patients. Membership is $49.00 a year and covers you and your dependents. Ask our team for more information.
    - If you are eligible & choose a pre-payment plan.

  As part of our compliance plan, as of 7/6/17 our office will be unable to extend any type of discounts other than those listed above.

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- If you need a statement of your account just ask and we will promptly print one for you.

- We work very hard to keep our fees as low as possible. It is the goal of this office to not have money as a barrier to care. If you should ever have concerns about finances, please feel free to talk to our doctors or staff. We will help you in any way possible to enable you to continue care as needed.

- If, for any reason, you have an account in arrears with our office and we are not able to establish a repayment plan, your account will be sent to collections. This is used only as a last resort. If this option must be used, a fee of up to, but no more than 50% of the balance owed by you will be added to your account. We will always work with you to get your account paid in full.

I understand that health and accident insurance policies are an arrangement between my insurance company and myself – not with this office. I authorize Healing Touch Chiropractic to release any medical information and to complete customary reports to assist me in collection from my insurance company. I understand that all fees for services rendered are due at the time of service and cannot be deferred to a later date.

I have read and understand the above policies.

_____ _____

Patient Signature Date