Family Chiropractic Center
20700 Chippendale Ave Ste 7
Farmington, MN 55024
651-460-9449

ABOUT THE PATIENT

Today's Date _____

Name _____ Birthdate _____ Age_____ Gender_____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ E-mail Address _____

Emergency Contact _____ Ph # _____

Your Employer _____ Type of Work _____

❑ Single ❑ Married ❑ Widowed Partner's Name _____

Are you pregnant? ❑ No ❑ Yes When is your due date? _____ ❑ Hospital Birth ❑ Mid-Wife ❑ Home Birth ❑ Birth Center

Kid's Name _____ Age _____ Kid's Name _____ Age _____
Kid's Name _____ Age _____ Kid's Name _____ Age _____

Have you had acupuncture before? □ No □ Yes If Yes, Where? _____

When was the last time you were treated? _____ What type of care was received? ❑ Acute ❑ Wellness ❑ Both

How did you hear about us? _____ Whom may we thank for referring you? _____

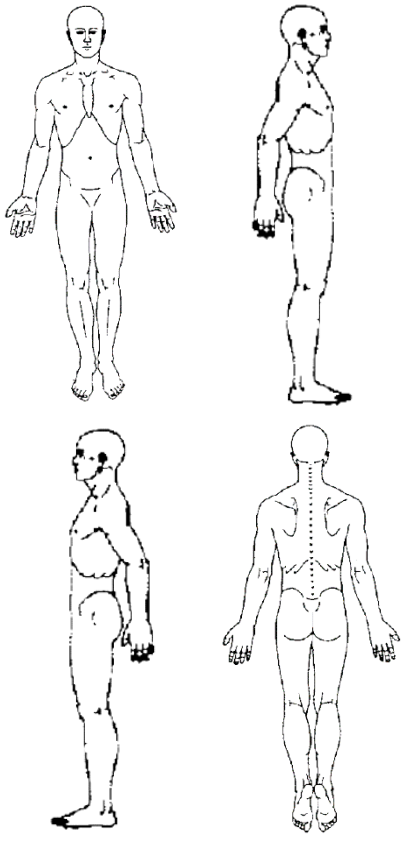
REASON FOR SEEKING CARE

1. _____ ❑ Mild ❑ Moderate ❑ Severe
How long has this been an issue? _____
Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb/Tingle ❑ Stabbing ❑ Constant ❑ Intermittent
❑ Better with pressure ❑ Worse with pressure ❑ Better with cold ❑ Better with heat
❑ Worse in the morning ❑ Worse in evening
❑ Pain radiates to_____
This affects my: ❑ Sleep ❑ Work ❑ Daily Routine ❑ Sitting ❑ Driving
❑ Other: _____

2. _____ ❑ Mild ❑ Moderate ❑ Severe
How long has this been an issue? _____
Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb/Tingle ❑ Stabbing ❑ Constant ❑ Intermittent
❑ Better with pressure ❑ Worse with pressure ❑ Better with cold ❑ Better with heat
❑ Worse in the morning ❑ Worse in evening
❑ Pain radiates to_____
This affects my: ❑ Sleep ❑ Work ❑ Daily Routine ❑ Sitting ❑ Driving
❑ Other: _____

3. _____ ❑ Mild ❑ Moderate ❑ Severe
How long has this been an issue? _____
Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb/Tingle ❑ Stabbing ❑ Constant ❑ Intermittent
❑ Better with pressure ❑ Worse with pressure ❑ Better with cold ❑ Better with heat
❑ Worse in the morning ❑ Worse in evening
❑ Pain radiates to _____
This affects my: ❑ Sleep ❑ Work ❑ Daily Routine ❑ Sitting ❑ Driving
❑ Other: _____

Please mark all areas of concern



How did your symptoms begin? _____

What makes you better? _____

What makes you worse? _____

Have other treatments helped? _____

Patient Signature _____ Date_____

FAMILY
CHIROPRACTIC

HIPAA - Acupuncture

Consent for Purposes of Treatment, Payment and Health Care Operation

I consent to the use or disclosure of my identifiable health information by Miriah Mantik, LAc. for the purposes of diagnosis or providing treatment to, obtaining payment for my acupuncture treatments or to conduct health care operations. I understand that diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment or health care operations of the practice. The licensed acupuncturist is not required to agree to the restrictions that I may request.

I have the right to revoke this consent, in writing, at any time except to the extent that the practitioner has taken action in reliance on this consent.

I understand that the treating practitioner will not share my medical information with any non-licensed medical individuals unless authorized by me.

My *identifiable health information* means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. This identifiable health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

Miriah Mantik, LAc. reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by accessing the website or requesting the most current notice during any office visit.

_____ _____

Signature of Patient or Authorized Representative Date

_____

Printed Name and Relationship

_____ (initial) Please know there will be a **$45 fee** assessed for any appointments cancelled less than 24 hours before your scheduled appointment. There will be an **$95 fee** for no call/ no show charged at the time of your missed appointment.

FAMILY
CHIROPRACTIC

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of an unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risk of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plan, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgement during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment of my present condition for any future condition(s) for which I seek treatment.

_____ _____

Signature of Patient or Authorized Representative Date

_____

Printed Name and Relationship

FAMILY
CHIROPRACTIC

COVID CONSENT TO TREAT

I understand hat the novel Coronavirus (COVID-19) has been declared a global pandamic by the World Health Organization (WHO). I further understand that COVID-19 is extemely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. Party of this office's role is to provide me with information to assist me in making informed choices. This proces is often referred to as "informed consent" and involves my understanding and agreement in regarding recommended care, and the benefits and risks associated with the provision of health care during a pandamic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

To proceed with receiving care, I confirm and understand the following)initial in all seven places provided):

_____ 1. I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted.

_____ 2. I understand that I am opting for an elective treatment that may not be urgent or medically necessary, and that I have the option to defer my treatment to a later date. However, while understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time.

_____ 3. I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care facility.

_____ 4. I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:
* Fever *Dry Cough *Sore Throat *Shortness of Breath
* Runny Nose * Loss of Taste or Smell

_____ 5. I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT in the past 14 days traveled: 1) Outside of the United States to countries that have been affected by COVID-19; or 2) Domestically within the United States by commercial airline, bus, or train.

_____ 6. I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume risk of becoming infected with COVID-19 through this elective treatment and give my permission to you and the staff at your offices to proceed with providing care.

_____ 7. I have been offered a copy of this consent form.

I knowingly and willingly consent to the treatment with the full understanding and disclosure of the risks associated with receiving care during the COVID-19 pandemic. I confirm all of my questions were answered to my satisfaction. I have read, or have had read to me, the above COVID-19 risk informed consent to treat. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek care from this office.

_____ _____

Signature of Patient or Authorized Representative Date

_____

Printed Name and Relationship