



APPLICATION FOR CARE AT EMBRACE CHIROPRACTIC

PRACTICE MEMBER HEALTH REVIEW: Today's Date: ___ / ___ / ___ PMID#: _____

Name: _____ Birth Date: ___ - ___ - ___ Male Female

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

Home Phone: _____ Cell Phone: _____

E-mail Address: _____ Marital Status: Single Married Divorced Widowed

Employer: _____ Occupation: _____

Spouse's Name _____ Spouse's Employer: _____

Number of children, names, and ages: _____

Are you pregnant? No Yes How far along? _____

Previous Chiropractic Care: No Yes When: _____ Where: _____

Name & Number of Emergency Contact: _____

Relationship: _____

Whom may we thank for referring you? Google Facebook Instagram Event Family/Friend Other: _____

HISTORY of COMPLAINT:

Please list the condition(s) that brought you to this office:

When did the problem(s) begin? _____

When is the problem at its worst? AM PM Pains are: Sharp Dull Constant Intermittant

Did this issue occur due to a motor vehicle accident? No Yes If yes, in which state? _____

Have you suffered from this before? No Yes If yes, how many times? _____ When was the last episode? _____

Have you tried other treatments: No Yes If yes, please state what type of treatment: _____

Who provided it: _____ How long ago? _____

Were the results Favorable Unfavorable Please explain. _____

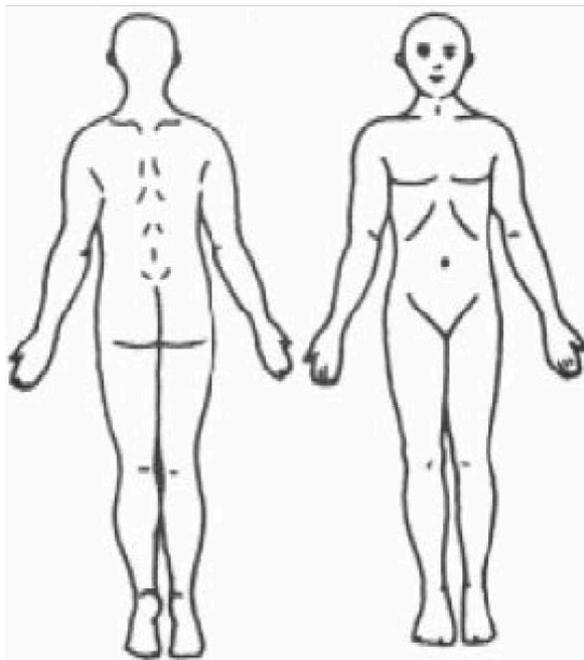
Please mark **P** for in the **Past**, **C** for **Currently** have, or **N** for **Never**

- | | | | | |
|--|----------------------------|---------------------|------------------------------|--------------------------|
| ___ Headache | ___ Pregnant (Now) | ___ Dizziness | ___ Prostate Problems | ___ Ulcers |
| ___ Neck Pain | ___ Frequent Colds/Flu | ___ Loss of Balance | ___ Impotence/Sexual Dysfun. | ___ Heartburn |
| ___ Jaw Pain, TMJ | ___ Convulsions/Epilepsy | ___ Fainting | ___ Digestive Problems | ___ Heart Problem |
| ___ Shoulder Pain | ___ Tremors | ___ Double Vision | ___ Colon Trouble | ___ High Blood Pressure |
| ___ Upper Back Pain | ___ Chest Pain | ___ Blurred Vision | ___ Diarrhea/Constipation | ___ Low Blood Pressure |
| ___ Mid Back Pain | ___ Pain w/Cough/Sneeze | ___ Ringing in Ears | ___ Menopausal Problems | ___ Asthma |
| ___ Low Back Pain | ___ Foot or Knee Problems | ___ Hearing Loss | ___ Menstrual Problem | ___ Difficulty Breathing |
| ___ Hip Pain | ___ Sinus/Drainage Problem | ___ Depression | ___ PMS | ___ Lung Problems |
| ___ Back Curvature | ___ Swollen/Painful Joints | ___ Irritable | ___ Bed Wetting | ___ Kidney Trouble |
| ___ Scoliosis | ___ Skin Problems | ___ Mood Changes | ___ Learning Disability | ___ Gall Bladder Trouble |
| ___ Numb/Tingling arms, hands, fingers | | ___ ADD/ADHD | ___ Eating Disorder | ___ Liver Trouble |
| ___ Numb/Tingling legs, feet, toes | | ___ Allergies | ___ Trouble Sleeping | ___ Hepatitis (A,B,C) |

Are you currently taking any medications (prescription or non-prescription)? No Yes

If yes, please list: _____

PLEASE CIRCLE the symptomatic area of pain/discomfort on the following diagram:



INFORMED CONSENT

REGARDING Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

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 knowledgeably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

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 vertebrae 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 removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.

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 methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. 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 also 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. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition, there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that practice members 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.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Embrace Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. Having this knowledge, I knowingly authorize chiropractic care with Embrace Chiropractic by any means, method, and or techniques, the doctor deems necessary at any time throughout the entire clinical course of my care.

Missed Appointments Policy:

We strive to provide you with the utmost professionalism and excellence of service. Our commitment to your well-being and health is something we take seriously. We care about you and realize it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need and to the actions we recommend to you. Your faithfulness to the recommended number of adjustments is key to ensuring optimum results.

With the exception of emergencies, it is vital that you keep all your appointments. Reminder cards and texts are utilized to help you save the date. If you need to re-schedule an appointment, please call our office at 330-953-1641 or text our texting line, and arrange for a make-up appointment. We would prefer the make up appointment to be within the same week. In the instance of 2+ cancellations/reschedules without 24 hours' notice, we reserve the right to charge a fee, or deduct visits. In the instance of a no call/no show appointment without notice by phone call or text, we reserve the right to charge a fee, or deduct visits. Thank you for your understanding. We greatly appreciate you as our practice member and strongly desire excellent results and success for you!

I understand and agree to all the information written above.

Practice Member or Authorized Person's Signature

____/____/____
Date



Witness Initials

Pediatric Consent for Minor Practice Member

REGARDING Parental Consent for Minor Practice Member

Practice Member Name: _____ Practice Member Age: _____ DOB: _____

Printed name of person legally authorized to sign for

Practice Member: _____

Signature: _____

Relationship to Practice Member: _____

In addition, by signing below, I give permission for the above named minor practice member to be managed by the doctor even when I am not present to observe such care.

Printed name of person legally authorized to sign for

Practice Member: _____

Signature: _____

Relationship to Practice Member: _____

X-ray Imaging Informed Consent

REGARDING Non-Pregnancy Verification

FEMALES ONLY → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

The first day of my last menstrual cycle was on ____ - ____ - ____ (Date)

I hereby notify all concerned that I neither suspect nor know positively at this time that I may be pregnant. I release this clinic from any and all damages arising from any and all procedures of diagnostic x-rays or care nature with reference to the possibility of pregnancy.

Practice Member or Authorized Person's Signature

____/____/____
Date

EMBRACE CHIROPRACTIC NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances.

PERMITTED DISCLOSURES:

- 1) Treatment purposes - discussion with other health care providers involved in your care.
- 2) Inadvertent disclosures - open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
- 3) For payment purposes - to obtain payment from your insurance company or any other collateral source.
For workers compensation purposes - to process a claim or aid in investigation.
- 4) Emergency - in the event of a medical emergency we may notify a family member.
- 5) For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
- 6) To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
- 7) For military, national security, prisoner and government benefits purposes.
- 8) Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.

I hereby authorize payment to be made directly to Embrace Chiropractic for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application, or copies thereof, for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Embrace Chiropractic for any and all services I receive at this office.

Your Rights

- 1) To receive an accounting of disclosures.
- 2) To receive a paper copy of the comprehensive "Detail" Privacy Notice.
- 3) To request mailings to an address different than residence.
- 4) To request restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
- 5) To inspect your records and receive one copy of your records at no charge, with notice in advance.
- 6) To request amendments to information. However, like restrictions, we are not required to agree to them.
- 7) To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. At your request, we will provide you with a copy of your x-rays in our files. **The fee for copying your x-rays onto a disc is \$49.00.** This fee must be paid in advance. (Please note: x-rays are utilized in this office to locate and analyze vertebral subluxations. These x-rays are not used to investigate for medical pathology. The doctor does not diagnose or treat medical conditions; however, if any abnormalities are noted, we will bring it to your attention so you can seek proper medical advice.

Practice Member's Name

DOB

HR#

Practice Member's Signature

Date

Witness

Date