Innate Chiropractic Healing Arts Center
Dr. Jackie St.Cyr, Family Wellness Chiropractor
8100 Washington Ave #210, Houston, TX 77007
(713) 521-2104 www.N8Chiro.com

Welcome to our office!

It is our pleasure to serve you today!
To help us better understand your needs, please answer the following questions:

ADULT PATIENT - CONFIDENTIAL HEALTH HISTORY

First Name _____ **Middle Name** _____ **Last Name** _____

Nick Name _____ **Date of Birth** _____ **Gender** _____

Mailing Address _____

City _____ **State/Province** _____ **Zip Code** _____

Who referred you or how were you inspired to visit our office? (Please give details.)

_____

Like all the patients we care for, why did you choose our office over others in the area?

_____

COMMUNICATIONS: To conserve resources, we generally utilize EMAIL and TEXT for regular communications and reminders.

May we Email you?
◯ Yes ◯ No

May we Text you?
◯ Yes ◯ No

Email _____

Cell Phone (000) 000-0000 _____

Work Phone _____

Home Phone _____

Work Status
☐ Full time ☐ Part time
☐ Retired ☐ Unemployed
☐ Self Employed

Active Student?
☐ Yes ☐ No
☐ Full time ☐ Part time

Military?
☐ Yes ☐ No ☐ Active
☐ Inactive ☐ Retired ☐ Other

Employer / Company Name _____

Your Occupation _____

Financially Responsible Party _____

Marital Status

◯ Single ◯ Life Partner ◯ Divorced
◯ Widowed ◯ Married ◯ Other

Number of Children _____

Spouse / Significant Other Full Name _____ **Phone#** _____

Emergency Contact _____ **Relationship to You** _____ **Phone#** _____

ARE YOU MEDICARE ELIGIBLE?

If you are MEDICARE ELIGIBLE, please check "YES", and please read and sign the "Special Notice for Medicare Patients" at the end of this form. ◯ Yes ◯ No

MY HEALTH CONCERNS

Please list your health concerns (reasons for seeking care here) and rate the severity of each from 1-10 with 10 being the worst.

CHIEF PHYSICAL CONCERNS

#1 Physical Concern _____ **Severity (1-10)** _____

#2 Physical Concern _____ **Severity (1-10)** _____

#3 Physical Concern _____ **Severity (1-10)** _____

#4 Physical Concern _____ **Severity (1-10)** _____

CHIEF EMOTIONAL CONCERNS

#1 Emotional Concern _____ **Severity (1-10)** _____

#2 Emotional Concern _____ **Severity (1-10)** _____

#3 Emotional Concern _____ **Severity (1-10)** _____

#4 Emotional Concern _____ **Severity (1-10)** _____

Have you seen any other doctors or received any other care for these conditions?

◯ Yes ◯ No

If YES, what type of care have you received?

_____

What were the results of that care?

_____

Are the above concerns, or your purpose for visiting with us, related to any of the following? (Check any that apply)

◯ Current Auto Accident ◯ Current Job Injury ◯ Other Accident ◯ None

If so, please explain.

Please choose ALL of the following statements that apply to how you FEEL about your condition.

- ☐ I feel helpless; like nothing works.
- ☐ I feel this is a pattern that is happened to me before; it is back again.
- ☐ I am looking for assistance in becoming healthier so I can move past my health concern.
- ☐ I don't know how I feel. I am too preoccupied with my present condition
- ☐ I don't like what I am feeling and I hope you can fix it.
- ☐ I feel there is a message by body is giving me.
- ☐ I realize my condition may be a necessary experience in getting to the real problem.
- ☐ I am looking for something to help me enhance my quality of life and further enhance my wellness.

Why do you think your body and/or mind is not healing?

MY CHIROPRACTIC & SPINAL HEALTH HISTORY

Please tell us about your past experience with Chiropractic Care.

Research shows that your spine should be checked regularly. How many times have you visited a chiropractor in your lifetime?

- ◯ Never
- ◯ Once
- ◯ Twice
- ◯ A few times
- ◯ Over 24 times
- ◯ I lost count and I wouldn't live without it

When (if ever) was your last complete spinal examination? _____

When (if ever) were X-Rays last taken of your spine? _____

If female, are you pregnant? ◯ Yes ◯ No **If YES, due date?** _____

Have you ever been told you have a spinal curvature, scoliosis, spinal arthritis, disc problems, osteoporisis or other spinal problems? If YES, please explain in detail.

Have you ever had spinal surgery? If YES, please explain in detail.

MY HISTORY OF LIFE STRESS & TRAUMA

Chiropractic science is based upon the location and adjustment of Vertebral Subluxations.
Spinal Subluxations are caused by any stress that your body can not properly perceive, adapt to, or recover from.
These stresses may be PHYSICAL, CHEMICAL, or EMOTIONAL / MENTAL in nature.

ABOUT MY BIRTH

Please tell us about any problems associated with your mother's pregnancy with you, or any trauma involved with your birth:

PHYSICAL STRESS & TRAUMA

VEHICULAR ACCIDENTS: Have you ever been involved in a collision or near collision? (Check all that apply)

- ☐ automobile
- ☐ motorcycle/moped
- ☐ bus
- ☐ train
- ☐ bicycle
- ☐ airplane
- ☐ skateboard
- ☐ skiing

OTHER PHYSICAL TRAUMA: (Check all that apply)

- ☐ physical fight
- ☐ armed forces / combat
- ☐ abuse
- ☐ knocked unconscious
- ☐ broken bones
- ☐ extensive dental work
- ☐ childhood illness
- ☐ used crutches/cane

TRAUMA RELATED MEDICAL INTERVENTIONS: Have you had any of the following? (Check all that apply)

- ☐ hospitalization
- ☐ surgery
- ☐ organ removal
- ☐ spinal tap
- ☐ spinal injections
- ☐ physiotherapy
- ☐ neck collar
- ☐ spinal brace
- ☐ traction
- ☐ special shoes
- ☐ orthotics or heel lift
- ☐ radiation treatments
- ☐ blood transfusion
- ☐ chemotherapy
- ☐ correcorrective shoes
- ☐ extensive diagnostic x-rays

SPORTS & LEISURE: (Check all that apply)

- ☐ currently active in sports
- ☐ previously active in sports
- ☐ suffered sports injuries
- ☐ injured in fall
- ☐ read for prolonged times
- ☐ play a musical instrument
- ☐ watch TV in poor posture
- ☐ I wear glasses

DURING THE DAY, I: (Check all that apply)

- ☐ sit
- ☐ stand
- ☐ walk
- ☐ drive
- ☐ do desk work
- ☐ phone work
- ☐ mechanical work
- ☐ heavy lifting

I EXERCISE:

- ◯ daily
- ◯ weekly
- ◯ monthly
- ◯ never

Is there any other information you would like to share regarding any physical trauma?

CHEMICAL STRESS & TRAUMA

DO YOU OR HAVE YOU EVER: (Check all that apply)

- ☐ taken prescription drugs
- ☐ over the counter drugs
- ☐ taken antibiotics
- ☐ worked with chemicals
- ☐ worked with fumes/smoke
- ☐ worked with dust
- ☐ been vaccinated
- ☐ other

MEDICATIONS ARE CHEMICALS THAT CAN AND MAY CAUSE SPINAL SUBLUXATIONS AND IMBALANCES IN NERVOUS SYSTEM FUNCTION. Are you now taking any drug (prescription or over the counter) regularly? If so, please list them:

Drug #1:	**Reason Prescribed:**	**Date Prescribed:**
Drug #2:	**Reason Prescribed:**	**Date Prescribed:**
Drug #3:	**Reason Prescribed:**	**Date Prescribed:**
Drug #4:	**Reason Prescribed:**	**Date Prescribed:**
Drug #5:	**Reason Prescribed:**	**Date Prescribed:**

If you were PREVIOUSLY taking any other medications regularly, please list and explain.:

DO YOU CONSUME? (Check all that apply)

☐ alcohol	☐ coffee/caffeine	☐ tobacco	☐ artificial sweetners
☐ soda	☐ tap water	☐ recreational drugs	☐ diet food
☐ refined sugar	☐ eggs	☐ cooked/canned vegetables	☐ raw vegetables
☐ fresh fruit	☐ whole grains	☐ dairy	☐ fried foods
☐ poultry	☐ fish	☐ seafood	☐ organic foods

The type of diet I usually follow is classified as:

_____

Is there any other information you would like to share regarding any chemical stress or trauma?

_____

MENTAL/EMOTIONAL STRESS & TRAUMA

The health of your spine can directly impact your mental/emotional state.

HOW DO YOU GRADE YOUR PHYSICAL HEALTH? ◯ Excellent ◯ Good ◯ Fair ◯ Poor ◯ Getting better ◯ Getting worse

RATE YOUR EMOTIONAL / MENTAL HEALTH: ◯ Excellent ◯ Good ◯ Fair ◯ Poor ◯ Getting better ◯ Getting worse

RATE YOUR OVERALL QUALITY OF LIFE: ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Getting better ☐ Getting worse

PLEASE RATE THE SEVERITY OF THE FOLLOWING STRESSORS IN YOUR LIFE FROM 1-10, 10 IS THE WORST.

Childhood Stress: _____ **Loss of a Loved One** _____

Change in Lifestyle _____ **Financial Stress** _____

Work Stress _____ **Home/Family Stress** _____

School Stress _____ **Personal Relationships** _____

Stress of Commuting _____ **Being Sick** _____

Depression/Anxiety _____ **Abuse** _____

Divorce/Seperate _____ **Parent's Divorce** _____

Is there any other information you would like to share regarding any mental / emotional stress or trauma?

_____

MY SELF-CARE HABITS

THINGS I DO CURRENTLY TO SUPPORT MY HEALTH INCLUDE:

- ☐ Drink plenty of water
- ☐ Pray/Meditate
- ☐ Maintain positive attitude
- ☐ Maintain proper weight
- ☐ Use a cervical pillow
- ☐ Massage therapy
- ☐ Dance
- ☐ EFT
- ☐ Exercise regularly
- ☐ Yoga/Pilates/Aerobics
- ☐ Self-improvement books
- ☐ Receive regular massages
- ☐ Attend religious services
- ☐ Hypnotherapy
- ☐ Psychotherapy
- ☐ Hobby
- ☐ Get plenty of rest
- ☐ Alcohol in moderation
- ☐ Eat organically grown food
- ☐ Counseling/Therapy
- ☐ Annual physical exam
- ☐ Drumming
- ☐ Breathwork
- ☐ Feldenkrais
- ☐ Acupuncture
- ☐ Homeopathic remedies
- ☐ Vitamins, minerals, herbs
- ☐ Orthotics/Heel Lefts
- ☐ Life coaching
- ☐ Karate/Martial Arts
- ☐ Reiki
- ☐ Other

Is there any other information you would like to share regarding your self-care habits?

_____

MY GOALS FOR CARE

People seek Chiropractic care for a variety of reasons. Some for relief of pain, some for correction of the cause of their pain, and others total body wellness and quality of life. When recommending a care program, our Doctor of Chiropractic will give recommendations to support your goals and for optimal spinal wellness. Please tell us your top three health care goals and the type of care you desire.

My #1 Health Goal _____

My #2 Health Goal _____

My #3 Health Goal _____

What type of care are you seeking in our office? (Please choose ONE that BEST describes you).

- ◯ RELIEF CARE: Symptomatic relief of pain or discomfort
- ◯ CORRECTIVE CARE: Correcting and relieving the cause of the problem as well as the symptoms
- ◯ COMPREHENSIVE CARE: Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care

Research shows that people in Network Care report changes in their physical state, mental/emotional states, their body's ability to adapt to stress, achieve a heightened quality of life and make more positive lifestyle choices. Which of these would most excite you for your own results and to share this work with your friends and family?

- ☐ Changes in Physical State
- ☐ Emotional/Mental State
- ☐ Better Adaptation to Stress
- ☐ Heightened Quality of Life
- ☐ Make Positive Lifestyle Choices

FINAL QUESTIONS

If we find subluxations in your spine, is there anything that might prevent you from following through with the doctor's recommendations? If so please explain:

_____

If you consider yourself ill, why do you feel you are ill?

_____

If you consider yourself well, why do you feel you are well?

_____

Is there anyting else you wish to share, which has not been discussed?

_____

Authorization & Signature

I certify that I am the patient or legal guardian listed above. I have read and understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office, the staff, and Doctors to examine and work with my condition through the use of Network Care Entrainments /Adjustments (and other appropriate care) to my spine and body, as he or she deems appropriate. I hereby authorize the office to release all information necessary to any insurance company, attorney, or adjuster for the purpose of possible, personal claim reimbursement of charges incurred by me. I understand and agree that all services rendered to me will be charged directly to me, and I'm responsible for payment at the time of service. I understand and agree that any health or accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will be immediately due upon suspension or termination of any future care plan.

I agree with this statement of authorization ☐ Yes

Signature

Date Signed

_____

Printed Name

_____

Email

_____

PLEASE CONTINUE BELOW TO READ AND SIGN CONSENT FOR CARE . . .

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UNDERSTANDING AND CONSENT FOR CHIROPRACTIC CARE

NetworkSpinal™ Care, aka Network Spinal Analysis (NSA), Network Chiropractic (Effective 08/15/25)

PLEASE READ AND SIGN

I hereby request and consent to receiving spinal care, including wellness education in this office by a chiropractor(s) who provides Network Care, a low force approach which has unique outcomes and clinical results. This practitioner(s) chooses to practice Network Care, as he/she is professionally and personally confident in regard to the safety and effectiveness of this form of care, has also been trained in traditional chiropractic care, and certified in the procedures of Network Care.

The purpose of this consent form is to help me better understand the nature of the services offered in this office and our mutual responsibilities. This fosters a more effective relationship and avoids misunderstandings regarding expectations. Having well understood expectations is anticipated to promote a greater sense of safety and healing.

Network Care does not attempt to manually, or by instrument, manipulate spinal fixations structurally (often associated with a snapping or popping sound), nor does it directly treat painful areas of the spine and body. Instead, by enhancing my body's awareness of itself and specifically my spine, I understand I can develop new strategies for healing, adapting to stress, and experiencing wellness. These strategies promote spontaneous self-correction and self-regulation of spinal tension patterns and healing.

Network Care consists of gentle touch contacts (called entrainment contacts) along the neck and back to achieve greater communication between the brain and body, and new sensory and motor strategies. Network Care adopts an approach associated with somatic (body/spinal awareness) training. There is a large body of research characterizing Network Care and documenting its unique and significant wellness benefits. I understand I may obtain copies of published research articles and/or abstracts online at www.epienergetics.org/research-resources.

I am aware that I will be receiving gentle touch Network adjustments, also called entrainments. Assessments of my progress will include monitoring of my spine and body awareness, responsiveness to inner rhythms, tension, and ease patterns. At regular intervals, following commencement of care, reassessments will be performed. These will include my personal perception of my wellness and my awareness of my spine and body-mind changes. My chiropractor(s) will report to me the improvement in my spinal and nervous system integrity and my ability to self-regulate tension and to reorganize my spine.

Network Spinal Care has advanced through a series of Levels of Care. Each Level of Care involves the development of new and unique spontaneous spinal wave motions, other body movements, and oscillations. These waves, which are suggested to be associated with greater spinal stability, distribution of energy, and the transfer of internal information, are also associated with greater wellness, improved quality of life, and increased life enjoyment.

I also understand that, in addition to Network Care and wellness education, my practitioner(s) may perform additional assessments and offer health/spinal care or advice that is consistent with my individual needs.

It has been explained to my satisfaction, and I understand that the care offered at this office is not aform of, or replacement for, the diagnosis or treatment of any symptom, disease, or malady. Instead, it is a form of wellness care and self-education that empowers my connection with my body-mind and helps my body develop new strategies for spinal and nervous system integrity and wellness. It develops new capacities in my body for the identification of, spontaneous release of, and redirection of tension,including those that are unique to Network Care.

It is common for people receiving Network Care to breathe more deeply and more fully, engaging the spine with their respiration, to spontaneously adapt postures that release or redistribute tension, to bust stress, and to experience more of their inner life energy. I understand it is common to experience a wider range of motion and emotion during care. It is common, as care progresses, to find new options in the body and in life, which often lead to significant life changes.

This form of care is NOT suggested for those individuals who wish to remove a symptom or condition without the occurrence of other fundamental changes in their lives. The care in this office often promotes significant changes in health choices, lifestyle, experience of the body-mind, emotion, and consciousness. Rather than attempting to simply return me to my previous state minus a symptom, this chiropractor instead chooses to help me achieve new levels of wellness and life potential that I may never have had before.

Although in this office we seek to help you develop new strategies for wellness and spinal and nerve system integrity, as a chiropractor the sole condition of concern is that of the vertebral subluxation. Our guidelines require that the following information be given to you and signed by you prior to commencing care.

In Network Care, we categorize these subluxations into two categories, a structural segmental distortion and a spinal cord/nerve elongation or stretching. Through the gentle force applications at the spine to enhance spinal and nerve system integrity, subluxations are corrected. This is the only condition that we address in our office.

The only condition we offer to diagnose and correct is the vertebral subluxation and loss of spinal and neural integrity in relationship to this. We do not offer to diagnose or treat any other condition, disease,or symptom. If during the course of our spinal assessment/examination we encounter non-chiropractic or unusual findings, we will advise you of this. If you desire advice on further diagnosis or treatment of this condition, situation, or circumstance, we will recommend that you seek the services of another health care provider whose practice is geared towards such differential diagnosis and treatment.

☐ I have read, or have had read to me, this Network Care Consent Form and I understand that the care in this office is different from what many consumers may expect from chiropractors practicing manipulative therapy. I agree to receive care, which consists of or includes Network Care and wellness education. I understand that I am not passive in the process, that I am an active participant in my care and in my healing.

Signature **Date Signed**

Printed Name **Email**

PLEASE CONTINUE BELOW TO READ AND SIGN FINANCIAL POLICIES . . .

Innate Chiropractic Healing Arts Center
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FINANCIAL POLICIES & FEES - (EFFECTIVE 08/15/2025)

We believe that finances should never be a reason to keep you from receiving quality Chiropractic Care. We are dedicated to providing you the best healthcare possible and we keep our fees “cash affordable” and family friendly.

NEW PATIENT PACKAGE (Includes all care for the first 3 visits, allowing a full experience of our care): $395

- History & Consultation, Posture & Structural Exam, 3D Body View Laser Foot Scan, CORE Score Computerized Spinal Scans
- First 2 Network Chiropractic Care Adjustments/Entrainments and 1 Massage Modality
- Doctor's Report of Findings & Recommendations (@ 2nd Visit)
- New Patient Orientation Class and Dinner With The Doc Events - for you and up to 4 adult guests

CHIROPRACTIC CARE FEES:

- Network Spinal Analysis Chiropractic Adjustment (NetworkSpinal) (97139): $80
- Somato Respiratory Integration (97139): $80
- Jeanie Rub Massage (97124): $40
- Intersegmental Traction aka “Roller Table" (97012): $40
- Chi Machine (97012): $40

EXAMINATION FEES:

- NEW PATIENT EXAM = History, Consult, Exams, CORE Score Scans, Foot Scan on initial visit and Report of Findings at return visit: $195
- 3D BodyView Laser Foot Scan Assessment: $80
- Progress Scan + Results Review (Required after the first 12 visits): $90
- Re-Evaluation + Results Review (Required after the first 24 visits and/or at other intervals in care): $110

FINANCIAL PLAN OPTIONS - PRE-PAID & AUTO-PAY CARE PLANS:

- Our pre-paid & auto-pay financial plans offer ZERO % FINANCING and a 5 - 20% DISCOUNT to save you time & money.
- FAMILY DISCOUNTS: Family is defined as those living in partnership in the same household with shared expenses. When one primary adult member (parent, spouse, significant other) is enrolled in a care plan and in regular care, additional immediate family members receive an additional 5% discount on care plans. We also have special ChiroKids fees for, children under 18, when their parents are on a regular care plan.
- Care Plan = An enrolled frequency of regular care as recommended by the doctor and that fits into your lifestyle.
- Financial Plan = How you agree to pay for care and the discounts received for one-time pay, monthly auto-debit, etc.

ACCEPCTED FORMS OF PAYMENT:

- Most services in our office are eligable for Flex & Health Savings Cards (FSA/HSA). We also accept Cash / Checks / Visa / MC / Discover / AMEX.

NON-INSURANCE & FINANCIAL RESPONSIBILITY:

- It is our policy to have you pay us directly for all services and products received at the time of service in our office.
- We do not file insurance and most insurance companies offer limited coverage for Wellness care.
- NOTE REGARDING INSURANCE: ***** Our care is Wellness based and many insurance companies, including Medicare, only cover structural/manual manipulation of the spine and do not cover our gentle care, NetworkSpinal Care, or any low-force techniques, or Wellness care.*****
- Medicare only pays for structural/manual manipulation (popping) and does not cover any other services by chiropractors.
- We do not guarantee that your policy will cover any of our services, but we will provide you with an account statement for you to submit for possible reimbursement.
- Said statement will reflect any discounts that you receive, and you should not collect reimbursement, or apply to deductible, more than your out-of-pocket expense.
- Due to government regulations, discounted offers may exclude Medicare and Medicaid members.

OTHER POLICIES & FEES:

- INSUFFICIENT FUNDS FEE - There is a $25 fee for a declined auto-debit payment or ISF check. Please notify us in advance to change or update a card on file for your plan.
- NO-SHOW FEE - There is a FULL VISIT FEE for a “NO-SHOW-NO-ADVANCE-CALL”, or it counts as a visit in your plan when you miss a visit without advanced notice.
- REIMBURSEMENT & FEES DUE AT EARLY CANCELLATION - Reimbursement for fees paid in advance for services not yet rendered (early cancellation / incomplete care plans) will be refunded, within 30 days, after pro-rating the services rendered to date. Any fees still due for services rendered will be due in full at the time of cancellation of a plan.

IMPORTANT REQUEST: THANK YOU FOR RESPECTING OUR SCHEDULED HOURS & AVAILABILITY FOR OTHERS

- **PLEASE ARRIVE 5 MINUTES EARLY TO CHECK-IN FOR ALL APPOINTMENTS so as to be on the table by the scheduled time.**
- **Please call or text ahead if you are going to be late** - don't stress, we can usually work you in.
- Please give **24-HOUR ADVANCE NOTICE** for any changes or cancellations for all appointments.
- There is a **FULL VISIT FEE for a “NO-SHOW-NO-ADVANCE-CALL**”, or it counts as a visit in a plan.

☐ I have read, understand, and agree to the terms of this financial policy. I may request a signed copy of this agreement at any time.

Signature **Date Signed**

_____

Printed Name **Email**

_____ _____

PLEASE CONTINUE BELOW TO READ AND SIGN PRIVACY NOTICE . . .

Innate Chiropractic Healing Arts Center
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HIPAA PRIVACY NOTICE - (EFFECTIVE 08/15/2025)

This office is required by federal law 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 summary of these circumstances. If at anytime you would like a more detailed explanation, you will find we have placed several copies of the comprehensive 'Notice of Privacy Practices' in the examination room.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care
2. Inadvertent disclosures - open treating area means open discussion. If you need to speak privately tothe doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from you or any other collateral source
4. For personal injury purposes - to process a claim or aid in investigation
5. Emergency - in the event of a medical emergency we may notify a family member
6. Public health & safety - to prevent or lessen a serious or eminent threat to the health or safety of a person or general public
7. To government agencies or law enforcement - to identify or locate a suspect, fugitive, material witness or missing person
8. For military, national security, prisoner, and government benefits purposes
9. Deceased persons - discussion with coroners and medical examiners in the event of a death
10. Telephone calls, emails, texts, or mailings for appointment reminders - we may call your cell, home or other number provided and leave messages, send emails, texts, postcards, or other mailings regarding a missed appointment or to inform you of changes in practice hours or upcoming events,etc.
11. New ownership - in the event this practice was ever sold the new owners would have access to your personal health information.

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Notice of Privacy Practices" Patient Privacy Notice
3. To request mailings to an address different than your 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 we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To request amendments to information; however, like restrictions we are not required to agree to them
6. To obtain one copy of your records at a reasonable fee as deemed by the Texas Chiropractic Board,when timely notice is provided (15 days). X-rays prescribed by our office are considered original legal records and we must keep them in our possession for at least 7 years. You can usually obtain a complimentary personal copy from the imaging center but if there is a fee you will be responsible for that fee.

COMPLAINTS: If you wish to make a formal complaint about how we handle your health information please contact our office directly. If you are still not satisfied with the manner in which this office handles your complaint you can submit a formal complaint to: DHHS, Office of Civil Rights, 200 Independence Ave. SW, Room 509F HHH Building, Washington DC 20201

7. I understand that the entrance to this office is a public entrance.

8. I understand that in seeking care in this office that an open/group adjusting room is part of my health & wellness care.

9. I understand that this office uses the Perfect Patient Website Service, ChiroTouch, and Review Wave systems for the purpose of running a paperless environment and that some personal information (i.e.name, date of birth, email address, cell phone, payment information, etc.) will be securely stored online thru these systems.

10. I understand that in order to maintain a high level of security, this office will keep a photo of me onfile for identification. I may refuse to have my photo taken and can substitute my Driver's License as an alternative source of identification.

11. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply if this office has already taken action in reliance on this consent.

12. I understand that if I revoke this consent at any time, this office has the right to refuse to treat me.

13. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then I will not be allowed to receive treatment in this office. I may receive a copy of this Patient Privacy Notice.

14. I understand my rights as well as the practice's duty to protect my health information and have conveyed any concerns to the staff. I further understand that this office reserves the right to amend this "Patient Privacy Policy" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

15. I am aware that a more comprehensive "Notice of Privacy Practices" is available to me and copies are available in the exam room. At this time, I do not have any questions regarding my rights or any of the information I have received.

☐ I have read, understand, and agree to the terms of this privacy policy. I may request a signed copy of this agreement at any time.

Signature **Date Signed**

_____

Printed Name **Email**

_____ _____

*** MEDICARE ELIGIBLE PATIENTS:** PLEASE CONTINUE BELOW TO SIGN SPECIAL MEDICARE NOTICE . . .

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SPECIAL NOTICE FOR MEDICARE PATIENTS - (EFFECTIVE 08/15/2025)

The Innate Chiropractic Healing Arts Center, Inc. and Dr. Jackie St.Cyr, D.C. are dedicated to providing you with the best chiropracic healthcare possible, with the goal of you reaching your optimal health and function. For that reason, we will always recommend what you will need for the maximum benefit of your condition. We will not make recommendations based only on what your insurance will cover.

The decision to proceed with care is always up to you, since your healthcare choices are a personal decision. With that in mind, this notice will help you understand what is and is not covered by Medicare in a chiropractic office, and what may be your responsibility.

Medicare covers ONLY traditional, structural spinal manipulation adjustments, when the doctor feels they meet Medicare's requirement of medical necessity. Network Spinal Analysis (NSA) (akaNetworkSpinal™ or Network Care) sessions are never a covered service under Medicare, because Medicare only covers Manual Manipulation of the spine that is deemed a Chiropractic Manipulative Treatment. NSA sessions do not meet Medicare's criteria. All of the following services that we deliver in our office are excluded by Medicare when ordered or delivered by a chiropractor.

This includes:

- Evaluation and Management Services (Examinations)
- Network Spinal Analysis (NSA) (aka NetworkSpinal™ or Network Care Chiropractic) - (Non-Manipulative Adjustments)
- Somato Respiratory Integration (SRI)
- Intersegmental Traction (The Roller Table) and the Chi Machine
- Adjustments to areas other than the spine, such as shoulder, hand, leg or foot
- Durable medical equipment such as pillows and custom orthotic supports
- Nutritional Supplements

Remember, we never want to turn any patient away from care due to financial circumstances, whenever possible. We offer many options to assist you with your financial responsibility and will explain each of these to you in detail.

Please let us know about any questions you have related to your care here.

Signature **Date Signed**

Printed Name **Email**