Patient Information

First Name_____ Middle Initial_____ Last Name_____ Nickname_____

Address _____City_____ State _____ Zip _____

Home Phone # (_____) _____ Cell Phone # (_____) _____

E-Mail:_____ ☐ **Do not send me your wellness newsletter.**

SSN#_____ Age_____ Birth Date_____ Sex: M F Marital: M S W D How many children?_____

Occupation_____ Employer_____ Work Phone _____

Employer's Address_____ City _____ State, _____Zip_____

Spouse's Name_____ Employer_____ Work Phone_____

Employer's Address **(Spouse)** _____ City _____ State_____ Zip_____

Primary Care Physician (PCP):_____PCP Phone # _____

I give permission for this office to work with and share my health records with my PCP to better my overall health. ☐ **yes** ☐ **no**

Emergency Contact: _____Relationship_____ Phone_____

Who may we thank for referring you to our office? _____

Please provide your driver's license and all available insurance cards to our staff to photo copy.

Notice of Privacy Practices

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.

A signed consent form permits us to use your personal health information within our office for the purposes of treatment, receiving payment, and health care operations of our practice. It is the practice of this office to release only the minimum necessary information to any source not directly linked to hands on care and treatment of patients in our office as outlined in the Health Insurance Portability Accountability Act of 1996 (HIPAA). This includes third party payers, insurance companies, etc. In these cases your signed consent form permits us to release only enough information to complete the insurance claim process. In some cases, patients may wish to have their protected health information released. In those cases if the outside entity can provide us with a copy of a medical records release form signed by the patient then we will comply while still only providing only the minimum necessary information, or the amount of information requested by the patient. In cases of public health, HIPAA does not protect some information. Where we are required by law to release information to any law enforcement or public health agency, our office will only release the minimum information required by law to any outside entity. In all cases we will follow the most restrictive laws, state or federal, that apply in protecting your medical information.
You, as a patient have a right to see your medical record during normal office hours.

ADDITONAL USES OF YOUR HEALTH INFORMATION

Our staff may use your health information to remind you of appointments, send birthday or seasonal greeting cards, mailings, newsletters, information about our practice or other information we feel you may be interested in or may improve your health. We **will not** release a mailing list to any outside entity for solicitation of business not related to our office.

The Health Insurance Portability Accountability Act of 1996 (HIPAA) requires that we receive your permission before we use the personal information in your medical records for any reason. This consent form gives us permission to use your Protected Health Information (PHI) to carry out treatment, receive and/or as part of heath care operations of our practice. HIPAA also requires us to have a written notice of our privacy policy describing how medical information about you may be used and disclosed. If you so desire, this written notice is available at the front desk for you to read. You have the right to revoke, in writing, this consent form at any time. Although any services performed prior to the revocation of this consent are covered by this consent. We may revise our Notice from time to time. The effective date at the lower left hand side of this page indicates the date of the most current Notice in effect.

Patients or Guardian's Signature: _____ Date_____

Office Financial Policy

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces you're out-of-pocket expense and allows you to place your family under care. Most of our patients who have health or accident insurance will fall under one of the plans discussed in this policy. We ask that you read and understand our policy as it applies to your particular situation.

Patients without Insurance: All payments are expected at the time of service or by an authorized payment plan. Our payment plans make care an affordable part of your family health care.

Patients with Insurance: All deductibles, co-insurance and co-payments are expected at the time of service or an authorized payment plan. You are considered a cash patient until you bring in your completed insurance forms and we qualify and accept your insurance coverage. We do not accept assignment for secondary insurance carriers, but will be happy to provide you with a claim form for your secondary carrier.

Workers Compensation: If you are injured on the job, care should be paid for under your employer's Workman's Compensation Insurance. You will need to inform your employer of the accident immediately and obtain the name and address of their insurance carrier. If you or your employer do not provide us with this information, or if you suspend or terminate care against physicians' recommendations; any fees for services rendered are due immediately from you.

Personal Injuries or Auto Accidents: If you have not already done so, please notify your auto insurance carrier of your accident immediately. We will have you fill out the proper documents so we can file claims to the responsible party. It will be helpful if you know your insurance company's phone numbers, policy number, and accident claim number when you fill out the paper work. We will call your Adjuster to gather the information we need in order to file. If you reach the maximum amount payable under your auto insurance, we will file the claims to your Health Insurance. Although you are ultimately responsible for your bill, we will do whatever we can to secure reimbursement from your insurance carrier. Once the claim is settled or if you suspend or terminate care against physicians' recommendations, any remaining fees are due immediately from you. If there is a 3rd party involved (such as an attorney), you will be asked to make partial payments as care is received, and both you and your attorney will be asked to sign an Assignment Lien.

Medicare: Medicare covers for **spinal adjustments only**. Please let us know if you are eligible for Medicare and we will cover the specifics with you personally.

Our fees are considered usual, customary and reasonable by most insurance companies, and therefore are covered up to the maximum allowance determined by each carrier. If your insurance carrier has not paid your claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within (90) days of submission, you accept responsibility for payment in full of any outstanding balance. If at (120) days we have not received payment on your outstanding balance, you authorize us to automatically charge your remaining balance on your credit card that we have secured on file. If we find it necessary to turn your account over for collections, you will be responsible for collection fees, attorney fees, in addition to unpaid balance plus interest of 24% APR.

I agree that in the event I receive any check, draft, or other payment subject to this Agreement, such monies will be held in trust for provider. I will immediately deliver said check, draft or payment to provider. Active Chiropractic, P.A. agrees to apply the proceeds from said check, draft or payments to my debt for services rendered. I agree to waive any applicable statute of limitation that may at any time interfere with Provider's right to collect for services rendered by provider to patient.

- I understand that there is a $40.00 returned check fee, plus any costs involved. This cost may include any attorney fees necessary in collecting this debt.
- I authorize the doctor and his staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjusters, case nurse, claims reviewer, employer, health care provider or attorney in order to process any claims for reimbursement of charges incurred by me as a result of professional services rendered and hereby release him/her of any consequences thereof. I hereby authorize and direct payment of any medical/chiropractic expense benefits allowable to the doctor as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the assignee.
- The assignments and agreements contained in this document may not be revoked by the patient without the express written consent of the provider.
- A copy of this document shall be as binding as the document bearing original signatures

I have read, understand, and agree to the aforementioned polices regarding payment for services received in this clinic.

_____	_____	_____
Patients Name	Signature of Patient or Guardian	Date

Patient Health Questionnaire

Name: _____ **Date:** _____

History of Present Injury/ Illness: Please list below in order of importance the complaint(s) you have, also the estimated date it started.

1. **Complaint # 1**_____ How Long? _____
2. **Is this complaint related to an accident?** 1. ☐ YES 2. ☐ NO If yes describe:_____
3. **Have you had similar symptoms in the past?** 1. ☐ YES 2. ☐ NO If yes when? _____
4. **How did your symptoms begin?(sudden onset, gradual onset, lifting, ect.)**_____
5. **How are your symptoms changing?** a.☐ GETTING BETTER b.☐ GETTING WORSE c.☐ NOT CHANGING
6. **During the past 4 weeks:** None Mild Moderate Intense Excruciating

   a. Indicate the average intensity of your symptoms ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
7. **How do your symptoms affect your ability to perform daily activities such as working or driving, or social activities?**
8. a. (0= no effect on activities, and 10= no possible activities) ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
9. **Describe the nature of your symptoms: (Mark all that apply)**

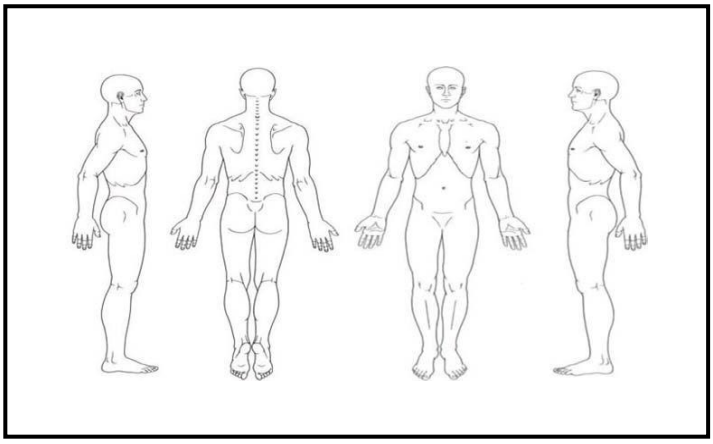
   a.☐ Burning b.☐ Dull c.☐ Numb d.☐ Radiating

   e.☐ Sharp f.☐ Shooting g.☐ Stabbing

   h.☐ Tightness i.☐ Tingling j.☐ Throbbing

   k.☐ Other:_____

Indicate where you have pain or other symptoms in diagram below



10. ***What makes your pain better?*** **(Mark all that apply)**

    a.☐ Ice b.☐ Heat c.☐ Laying down d.☐ Sleep/Rest

    e.☐ Sitting f.☐ Standing g.☐ Stretching h.☐ Walking

    i.☐ Pain Medicines j.☐ Acupuncture

    k.☐ Chiropractic treatment l.☐ Physical Therapy

    m.☐ Nothing helps n. ☐ Other:_____
11. **What is your expectation from care? (Mark all that apply)**

    a. ☐ Explanation of my condition b. ☐ Reduce symptoms c. ☐ Become pain free d. ☐ Correct the cause of my condition

    e. ☐ Resume normal activity f. ☐ Restore normal function to the spine and nervous system g. ☐ Learn how to care for this condition on my own
12. **How often do you experience the above symptoms?**

    a.☐ Constantly (76-100% of the day) b.☐ Frequently (51-75% of the day) c.☐ Occasionally (26-50% of the day) d.☐ Intermittently (0-25% of the day)
13. **What makes your condition worse and/or activities affected by this condition? (Mark all that apply)**

    a.☐ Bathing b.☐ Bending c.☐ Care of others/ pets d.☐ Carrying Objects e.☐ Climbing Stairs f.☐ Concentrating

    g.☐ Cooking/cleaning h.☐ Computer work i.☐ Crouching/squatting j.☐ Doctors visits k.☐ Eating l.☐ Exercise/sports

    m.☐ Lifting n.☐ Light/sound o.☐ Lying down p.☐ Personal hygiene/ grooming q.☐ Reaching up/down r.☐ Reading/watching TV

    s.☐ Sexual Activity t.☐ Shopping u.☐ Sitting v.☐ Standing w.☐ Turning/twisting x.☐ Walking y.☐ Working z.☐ Yard work

13. ***Who have you seen for this symptoms?*** 1. ☐No One 2. ☐Chiropractor 3. ☐Medical Doctor 4. ☐Physical Therapist 5. ☐Massage

    a. What treatment did you receive and when? _____

    b. What tests have you had for this symptoms 1. ☐X-rays date: _____ 2. ☐CT Scan date: _____

    and when were they performed? 3. ☐ MRI date: _____ 4. ☐Lab Work date: _____

Patient Health Questionnaire

Name: _____ **Date:** _____

History of Present Injury/ Illness: Please list below the 2nd complaint you may have, also the estimated date it started.

1. **Complaint # 2**_____ How Long? _____
2. **Is this complaint related to an accident?** 1. ☐ YES 2. ☐ NO If yes describe:_____
3. **Have you had similar symptoms in the past?** 1. ☐ YES 2. ☐ NO If yes when? _____
4. **How did your symptoms begin?(sudden onset, gradual onset, lifting, ect.)**_____
5. **How are your symptoms changing?** a.☐ GETTING BETTER b.☐ GETTING WORSE c.☐ NOT CHANGING
6. **During the past 4 weeks:**

	None	Mild		Moderate				Intense		Excruciating
a. Indicate the average intensity of your symptoms	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9 ☐10

7. **How do your symptoms affect your ability to perform daily activities such as working or driving, or social activities?**
8. a. (0= no effect on activities, and 10= no possible activities) ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
9. **Describe the nature of your symptoms: (Mark all that apply)**

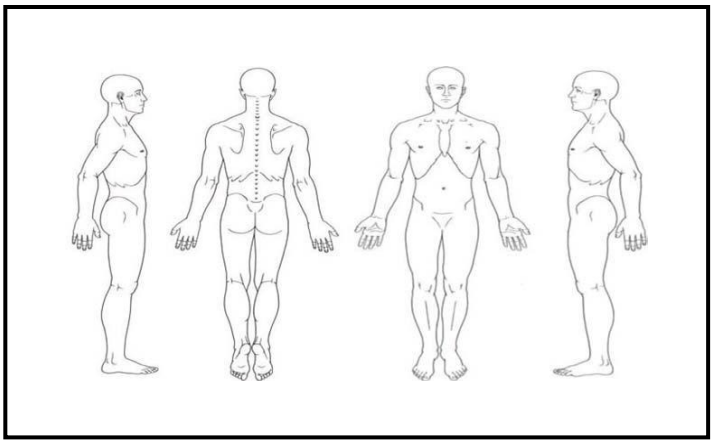
a.☐ Burning b.☐ Dull c.☐ Numb d.☐ Radiating

e.☐ Sharp f.☐ Shooting g.☐ Stabbing

h.☐ Tightness i. ☐ Tingling j.☐ Throbbing

k.☐ Other:_____

Indicate where you have pain or other symptoms in diagram below



10. **What makes your pain better? (Mark all that apply)**

a.☐ Ice b.☐ Heat c.☐ Laying down d.☐ Sleep/Rest

e.☐ Sitting f.☐ Standing g.☐ Stretching h.☐ Walking

i.☐ Pain Medicines j.☐ Acupuncture

k.☐ Chiropractic treatment l.☐ Physical Therapy

m.☐ Nothing helps n. ☐ Other:_____

11. **What is your expectation from care? (Mark all that apply)**

a. ☐ Explanation of my condition b. ☐ Reduce symptoms c. ☐ Become pain free d. ☐ Correct the cause of my condition

e. ☐ Resume normal activity f. ☐ Restore normal function to the spine and nervous system g. ☐ Learn how to care for this condition on my own

12. **How often do you experience the above symptoms?**

a.☐ Constantly (76-100% of the day) b.☐ Frequently (51-75% of the day) c.☐ Occasionally (26-50% of the day) d.☐ Intermittently (0-25% of the day)

13. **What makes your condition worse and/or activities affected by this condition? (Mark all that apply)**

a.☐ Bathing b.☐ Bending c.☐ Care of others/ pets d.☐ Carrying Objects e.☐ Climbing Stairs f.☐ Concentrating

g.☐ Cooking/cleaning h.☐ Computer work i.☐ Crouching/squatting j.☐ Doctors visits k.☐ Eating l.☐ Exercise/sports

m.☐ Lifting n.☐ Light/sound o.☐ Lying down p.☐ Personal hygiene/ grooming q.☐ Reaching up/down r.☐ Reading/watching TV

s.☐ Sexual Activity t.☐ Shopping u.☐ Sitting v.☐ Standing w.☐ Turning/twisting x.☐ Walking y.☐ Working z.☐ Yard work

14. **Who have you seen for this symptoms?** 1. ☐No One 2. ☐Chiropractor 3. ☐Medical Doctor 4. ☐Physical Therapist 5. ☐Massage

a. What treatment did you receive and when? _____

b. What tests have you had for this symptoms and when were they performed? 1. ☐X-rays date: _____ 2. ☐CT Scan date: _____ 3. ☐ MRI date: _____ 4. ☐Lab Work date: _____

Patient Health Questionnaire

Name: _____ **Date:** _____

History of Present Injury/ Illness: Please list below the 3rd complaint you have, also the estimated date it started.

1. **Complaint # 3**_____ How Long? _____
2. **Have you had similar symptoms in the past?** 1. ☐ YES 2. ☐ NO If yes when? _____
3. **Is this complaint related to an accident?** 1. ☐ YES 2. ☐ NO If yes describe:_____
4. **Have you had similar symptoms in the past?** 1. ☐ YES 2. ☐ NO If yes when? _____
5. **How did your symptoms begin?(sudden onset, gradual onset, lifting, ect.)**_____
6. **How are your symptoms changing?** a.☐ GETTING BETTER b.☐ GETTING WORSE c.☐ NOT CHANGING
7. **During the past 4 weeks:**

	None	Mild		Moderate				Intense		Excruciating
a. Indicate the average intensity of your symptoms	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9 ☐10

8. **How do your symptoms affect your ability to perform daily activities such as working or driving, or social activities?**
9. a. (0= no effect on activities, and 10= no possible activities) ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
10. **Describe the nature of your symptoms: (Mark all that apply)**

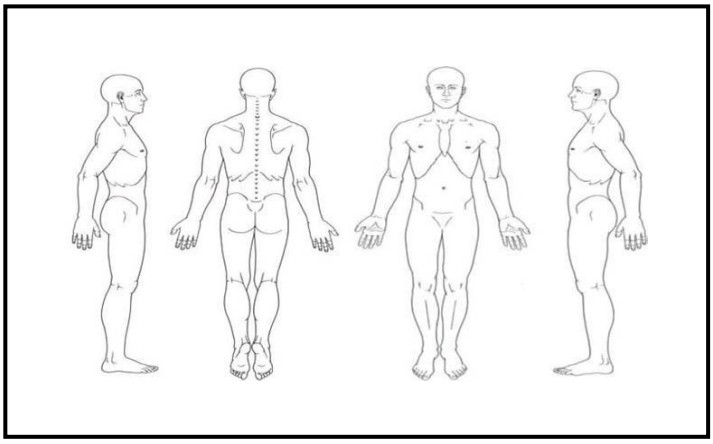
a.☐ Burning b.☐ Dull c.☐ Numb d.☐ Radiating

e.☐ Sharp f.☐ Shooting g.☐ Stabbing

h.☐ Tightness i. ☐ Tingling j.☐ Throbbing

k.☐ Other:_____

Indicate where you have pain or other symptoms in diagram below



11. ***What makes your pain better?*** **(Mark all that apply)**

a.☐ Ice b.☐ Heat c.☐ Laying down d.☐ Sleep/Rest

e.☐ Sitting f.☐ Standing g.☐ Stretching h.☐ Walking

i.☐ Pain Medicines j.☐ Acupuncture

k.☐ Chiropractic treatment l.☐ Physical Therapy

m.☐ Nothing helps n.☐ Other:_____

12. **What is your expectation from care? (Mark all that apply)**

a. ☐ Explanation of my condition b. ☐ Reduce symptoms c. ☐ Become pain free d. ☐ Correct the cause of my condition

e. ☐ Resume normal activity f. ☐ Restore normal function to the spine and nervous system g. ☐ Learn how to care for this condition on my own

13. **How often do you experience the above symptoms?**

a.☐ Constantly (76-100% of the day) b.☐ Frequently (51-75% of the day) c.☐ Occasionally (26-50% of the day) d.☐ Intermittently (0-25% of the day)

14. **What makes your condition worse and/or activities affected by this condition? (Mark all that apply)**

a.☐ Bathing b.☐ Bending c.☐ Care of others/ pets d.☐ Carrying Objects e.☐ Climbing Stairs f.☐ Concentrating

g.☐ Cooking/cleaning h.☐ Computer work i.☐ Crouching/squatting j.☐ Doctors visits k.☐ Eating l.☐ Exercise/sports

m.☐ Lifting n.☐ Light/sound o.☐ Lying down p.☐ Personal hygiene/ grooming q.☐ Reaching up/down r.☐ Reading/watching TV

s.☐ Sexual Activity t.☐ Shopping u.☐ Sitting v.☐ Standing w.☐ Turning/twisting x.☐ Walking y.☐ Working z.☐ Yard work

14. **Who have you seen for this symptoms?** 1. ☐No One 2. ☐Chiropractor 3. ☐Medical Doctor 4. ☐Physical Therapist 5. ☐Massage

a. What treatment did you receive and when? _____

b. What tests have you had for this symptoms and when were they performed? 1. ☐X-rays date: _____ 2. ☐CT Scan date: _____ 3. ☐ MRI date: _____ 4. ☐Lab Work date: _____

HEALTH HISTORY

Name:_____ **Date:**_____

NOTE: Please fill out ALL requested information, so we may provide the best treatment for your condition!

List any Allergies:

□ Animals □ Aspirin □ Bees □ Chocolate □ Dairy □ Dust □ Eggs□ Latex □ Molds □ Penicillin □ Ragweed/Pollen □ Rubber

□ Seasonal Allergies □ Shellfish □ Soaps □ Wheat □ X-Ray Dye □ Other: _____

List any Surgeries:

□ Back □ Brain □ Elbow □ Foot □ Hip □ Knee □ Neck □ Neurological □ Shoulder □ Wrist □ Other: _____

Check ALL Conditions you ever suffered from in the past:

Please circle any of the below conditions that are active problems now.

□ Ankle Pain □ Ankle Swelling □ Arm Pain □ Arm or back tingling □ Arthritis □ Asthma □ Back Pain □ Black or Bloody Stools

□ Bloating After Meals □ Blurred Vision □ Breast Lumps or Pain □ Broken Bones □ Bruise Easily □ Cancer □ Chest Pain □ Chronic Cough

□ Colitis □Constipation/Diarrhea □ Dental Problems □ Depression □ Diabetes □ Difficulty Breathing □ Dizziness □ Elbow Pain □ Epilepsy

□ Excessive Thirst □Excessive Urination □ Eye/Vision Problems □ Fainting □ Fatigue □ Foot Pain □ Frequent Colds/Ear Infections

□Frequent Nausea □ Frequent Urination □ Genetic Spinal Condition □ Hand Pain □ Headaches□ Hearing Problems □ Heart Problems□ Hepatitis

□ High Blood Pressure □ Hip Pain □ HIV □ Hives or Rash □ Hot Flashes □ Irregular/Painful/Excessive Menses □Irritable Bowel □ Jaw Pain

□ Joint Stiffness □ Knee Pain □ Liver Problems □ Leg Pain □ Menstrual Problems □ Mid-Back Pain □ Migraines □ Minor Heart Problem

□ Multiple Sclerosis □ Neck Pain □Nervousness □ Neurological Problems □ Painful Urination □ Pacemaker □ Parkinson's □ Prostate Problems

□Scoliosis □ Significant Weight Change □ Sprain/Strain □ Stroke/Heart Attack □ Surgical Implants □Tinnitus □ Other: _____

Family History: Check the following condition that applies for you, and your family.

	You	Father	Mother	Siblings	Uncle	Aunt	P. Grandparents	M. Grandparents
Arthritis								
Back Pain								
Cancer								
Diabetes								
Heart/High Blood Pressure								
HIV/AIDS								
Neurological Problems								
Prostate Problems								
Stroke								

Please List any accidents and approximate date of occurrence :

□ Auto Date: _____ □ Boating/ Recreational Date: _____ □Other_____ Date: _____

Social Habits: Check any of these habits and to what degree you do them.

	Heavy	Moderate	Light	None
Alcohol				
Coffee				
Tobacco				
Drugs				
Exercise				

Please list the medications and supplements you take and what condition or support you take them for.

List the medications taken and what it's for.		**List the supplements taken and for what reason**	
Medication	**Condition**	**Supplement**	**Reason**

Patients or Guardian's Signature: _____ Date: _____

INFORMED CONSENT

Consent for Treatment

I _____ understand that my outpatient registration, treatment or series of treatments by Active Chiropractic, P.A. is necessary because of my condition. I voluntarily authorize and consent to the usual examination and treatments ordered by the Doctor and staff.

Consent for Treatment of a Minor

I (We) being the parent, guardian, or custodians of _____, a minor, the age of _____,do hereby authorize and direct the doctors of Active Chiropractic, P.A. to perform in his/her judgment and necessary examinations, x-rays and recommended treatment for the condition.

As with any healthcare evaluation or procedure there are certain risks. There are several benefits associated with performing an evaluation. They include: working diagnosis of present condition, qualifying physical abilities and comparing performance results with the physical demands of a specific job category or classification. There are also expected benefits associated with participation in a treatment program. They include: increased flexibility, decreased pain, decreased inflammation, better circulation, reduced nerve interference; all combining to improve function in organs and systems and improving activities of daily living.

The nature of the chiropractic adjustment:

A chiropractic adjustment consists of a precise specific directional low impulse to restore normal motion and position by hands on or instrumental manipulation of the spine or extremities. It is performed for the purpose of realigning the joints of the body. An audible "pop" or "click" may be heard and you may feel or sense movement.

- **The potential risk involved in chiropractic adjustments.**

There are certain inherent risks which may arise during chiropractic manipulation. Those complications may include: muscle strain, tissue swelling, fractures, disc injuries, dislocations, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

- **The probability of those risks occurring.**

Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we attempt to determine during your case history, examination and X-ray evaluation. Stroke has been the subject of tremendous disagreement. One prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare."

- **Ancillary treatment.**

In addition to chiropractic adjustments, the following treatments are available and may be recommended: Cold Laser Therapy, Muscle Response Therapy, Ion Exchange Detoxification - EB 305 Therapy, Magnetic Therapy, Biosonic Sound Therapy, Allergy/Sensitivity Reprogram Therapy, Brimhall Protocol – Neurological/Rehabilitation and Nutritional Recommendations Therapy, Smoking Cessation Therapy, Weight-Loss Homeopathic Therapy, Heavy Metals and other Toxins Detoxification Therapy, and Aberrant Emotional Pattern/Limiting Belief Systems therapy. Some of the procedures listed above may be considered “Wellness Care” in our office and they may or may not be considered to be investigational or experimental at this time in the State of Kansas. By signing this form I acknowledge that I desire to have these procedures performed at this time and in the future as my treatment of choice. I also acknowledge that none of the above procedures are diagnostic in nature and are not to be considered a diagnosis for any ailment, but rather a therapeutic recommendation and alternative-adjunctive wellness treatment only. I also understand that the ancillary procedures may not be covered by my insurance and may not be filed with my insurance (if I have provided an insurance policy to be filed against) and that I am solely responsible for any charges incurred for these treatments. I understand that I will be held personally responsible for an amount of $ 10.00- $80.00 per unit of treatment. (This amount is an approximation only, based on the service(s) to be provided.) I further understand any additional service(s) could affect the amount of my financial responsibility.

Initial_____

If at any time, I decide to decline these treatments, I will do so in writing in advance of the treatments and present the written document of decline of these specific treatments to Doctors or staff of Active Chiropractic, P.A. These ancillary treatments involve the following additional significant risks: Mild bruising or tissue swelling may occur with acupuncture. Muscle strain or disc injuries may occur from traction and or rehabilitative exercises. Allergic reactions may occur from the kinesio-taping and nutritional supplements. However, all risks are extremely rare due to the precautions taken during these procedures.

- **The availability and nature of other treatment options.**
  Other treatment options for your condition include:

  - Self-administered, over-the-counter analgesics and rest
  - Medical care with prescription drugs such as an anti-inflammatory, muscle relaxants and painkillers.
  - Hospitalization with traction
  - Surgery

- **The potential risks inherent in such options and the probability of such risks occurring include:**

  - Overuse of over-the-counter medications produces undesirable side effects. If complete rest is impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, pain tolerance and self-discipline in not abusing the medicine. Professional literature describes highly undesirable effects from long term use of over-the-counter medicines.

  - Prescription muscle relaxants and painkillers can produce undesirable side effects and patient dependence. The risk of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, pain tolerance, self-discipline in not abusing the medicine and proper professional supervision. Such medications generally entail very significant risks - some with rather high probabilities.

  - Hospitalization in conjunction with other care bears the additional risk of exposure to communicable disease, iatrogenic (doctor induced) mishap and expense. The probability of iatrogenic mishap is remote, expense is certain; exposure to communicable disease is likely with adverse result from such exposure dependent upon unknown variables.

  - The risks inherent in surgery include adverse reaction to anesthesia, iatrogenic (doctor induced) mishap, all those of hospitalization and an extended convalescent period. The probability of those risks occurring varies according to many factors.

- **The risks and dangers of remaining untreated.**
  Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult to treat and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

Request for Records

I hereby authorize the Doctors and/or staff of Active Chiropractic, P.A. to request any medical records, x-rays, and specialized testing result, including serum and tissue testing results for the purpose of giving a better diagnostic picture. I permit a copy of this authorization to be used in requesting my records from any and all health care facilities, physician, and health care providers.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. A copy of this document shall be as binding as the document bearing original signatures

Printed Name of Patient: _____ Date: _____

Signature of Patient/Parent or Guardian (if a minor): _____