# VANELLA CHIROPRACTIC

*"Helping families get well and stay well for a lifetime."*

| | | | |
|---|---|---|---|
| Name | | | Sex: □ M □ F |
| DOB: | AGE: | Height: | Weight: |
| Marital Status: | | # of Children: | Occupation: |
| Address | | | Zip code: |
| Email: | | Cell Phone: | |
| How did you hear about us? | | | |

## TELL US ABOUT YOUR GOALS FOR CARE

In general, what do you consider your overall health goals:

| | | | |
|---|---|---|---|
| More energy | Better Sleep | Improved mental clarity/focus | Stronger immunity |
| Illness prevention | Easier breathing | Decrease reliance medications | Better posture |
| Increased relaxation | Slower aging | Higher stress resistance | Improved digestion |
| Increased flexibility | Improved performance | Other: _____ | |

What results are you hoping to experience by working with our office? _____

_____

How long do you anticipate it taking to reach these results? _____

What do you fee is causing your health concerns? _____

Have you every received chiropractic care? Yes / No With whom? _____

## HEALTH HISTORY

Please circle any symptoms or conditions you've experienced in the last 5 years:

| | | | |
|---|---|---|---|
| Neck pain | Back pain | Sinus problems | Carpal tunnel syndrome |
| Cancer | Insomnia | Fibromyalgia | Depression / Anxiety |
| Acid reflux | Hypertension | Osteoporosis | Colitis / Crohns / IBS |
| Headaches | Heart disease | Allergies / Asthma | Thyroid Imbalance |
| Stroke | Diabetes | Chronic fatigue | Restless legs |
| Incontinence | Sciatica | Other: _____ | |

Please list any diagnosed health conditions: _____

What medications do you take? _____

What supplements do you take? _____

Over the last 5 yearshas your health & quality of life: Decreased Increased Stayed the same

What other information about your health we should be aware of? _____

_____

## INFORMED CONSENT

I hereby request and consent to the performance of chiropractic procedures, including diagnostic thermography, surface emg, and HRV by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.
I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I agree to.

Patient Signature

Date

## FINANCIAL AGREEMENT

I do hereby designate Dr. Michael Vanella and Vanella Chiropractic to the fullest extent possible under the Employee Retirement Income Security Act of 1974 ("ERISA") and as provided in 29 CFR 2560-503-1(b) 4 to otherwise act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or health care expense(s) incurred as a result of the services I receive from the above names doctor. I hereby assign to the physician all payments for medical services rendered to myself and/or my dependents.

I understand that I am responsible for any amount not covered by insurance including co-pays and deductibles. In the event of non-payment, my account may be turned over to a collection agency or attorney, and I will also be responsible for the cost of collection, and/or 33.3% for legal fees, and does further agree to pay interest on the unpaid balance at the rate of 18% per annum from the date that said monies became due and payable.

Patient Signature _____ Date _____

## HIPAA Consent

**Uses and Disclosures:** We will use and disclose elements of your protected health information (PHI) in the following ways:

**Without your signed authorization**
· All treatment provided in this office
· To collect payment
· When release is required by law, including judicial settings and to health oversight regulatory agencies and law enforcement.
· In emergency situations or to avert serious health/safety/situations.

**Special cases**
· To contact you about appointment reminders, treatment alternatives and other health related benefits and services.
· To the sponsor of your health plan

**Other**
All other uses and disclosures by us will require us to obtain your written authorization in addition to any other permission you will provide us.
**Restrictions:** To request restricted access to all or part of your PHI. To do this, inform the office in writing of your request. We are not required to grant your request.
**Our duties:** We are required by law to maintain privacy of your PHI. We must abide by the terms of this

Patient Signature _____ Date _____