Informed Consent Document

FAMILY WELLNESS CENTER

Please read this entire document prior to signing it. Signature is valid for 1 year from the date signed below. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment – The primary treatment that I use, as a Doctor of Chiropractic, is spinal manipulative therapy. I will use that procedure to treat you I may use my hands, a special table, therapy tools, or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click", much as you have experience when you "crack" your knuckles, you may or may not feel a sense of movement.

Analysis, Examination, and Treatment – As part of the analysis, examination, and treatment, you are consenting to the following: Spinal/extremity manipulative therapy, range of motion testing, muscle strength testing, palpation, orthopedic testing, postural analysis, vital signs, basic neurology, hot/cold therapy, EMS/Tens therapy, rehabilitation, radiographic studies, and any other protocol that may be deemed fit for your case by the doctor.

The material risks inherent in chiropractic adjustment – As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocation, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. To the best of my knowledge I have never had a patient suffer with any complications from treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me. If treatment is not showing success within a reasonable amount of time for your case then other further recommendations shall be made.

The probability of those risks occurring – Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history, examination, radiographic views, and further evaluation of radiographs from Spinal Imaging, a diagnostic over read group. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and on in five million cervical adjustments. You may be at risk just by driving a car, getting your hair washed, sleeping with multiple pillows, and playing sports. We take great strides to protect our clients and their well-being.

The availability and nature of other treatment options – Other treatment options for your condition may include, but are not limited to: Self-administered, over the counter analgesics, and rest; Massage Therapy and Rehabilitation Therapy; Medical care and prescription drugs such as anti-inflammatory, muscle relaxants, and pain-killers; Pain Management referral; MRI or CT Scan referral; Hospitalization and Surgery. If you choose to use one of the above noted other treatment options, you should be aware that there are risks and benefits of such options. You may wish to discuss these with your primary medical physician.

The risks and dangers of remaining untreated – Remaining untreated may allow the formation of adhesions and reduce mobility, which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment, making it more difficult and less effective the longer it is postponed.

I have read ( ), or I have had this read to me ( ), along with verbal explanation of the treatment plan and options set forth by this clinic for my case. The above explanation of the chiropractic and related treatment has been discussed with me by Dr. Brian Brown, and I have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the recommended treatment. Having been informed of the risks, I hereby give my consent to treatment.

Name: _____ **Date:** _____

Signature: _____ **Doctor Signature:** _____

Dr. Brian Brown

Authorization Form and Financial Policy

Please initial next to each statement, indicating that you give authorization.
Some statements may not apply to you specifically.

FAMILY WELLNESS CENTER

Release of Information

_____ I hereby authorize Family Wellness Center to release my medical and financial data to my insurance company and/or attorney.

Protected Health Information

_____ I give permission for Family Wellness Center to use my address, phone number, and clinical records in order to contact me with appointment reminders, notifications, birthday/holiday related cards, possible alternative treatment options, and/or health related information.

_____ I give permission to disclose protected health information in the presence of anyone accompanying me into a treatment room or consultation room by my request.

_____ I give permission to disclose protected health information to any other specialist, if deemed necessary in further treatment of my care. This is to include the release of my medical records, photo identification, and insurance information.

_____ I understand certain times treatment could be rendered in open room areas, where other patients are also being treated. I am aware other patients in the office may overhear some of my protected health information during the course of my care. Should I need to speak to the doctor and/or staff privately, the opportunity will be given for a private conversation.

_____ I give permission for Family Wellness Center to send by mail or fax, any of my protected health information that is necessary for treatment, payment, and/or further services.

Consent to Leave Messages

I give my permission for messages to be left on my phone number(s) below regarding appointments, treatment needs, and payments/balances:
Cell # _____ Home # _____ OR _____ I prefer not to have voice messages from the office

Consent for Shared Information with Family & Friends
The name(s) listed below are family members or friends to whom I grant permission for Family Wellness Center to verbally discuss my care using their best judgment and grant them permission to disclose information that is relevant to my care, appointments, and/or relevant for payment information. **Yes** **No**

NAME	RELATIONSHIP	PHONE NUMBER
1. _____	_____	_____
2. _____	_____	_____

It will be my responsibility to keep this information up to date, as I recognize that relationships may change over time. This consent will be considered valid until such time that I revoke it in writing. I reserve the right to revoke it at any time.

Responsibility of Bill

_____ I accept full financial responsibility for charges and services rendered to me as a patient.

_____ I understand that services are rendered and charged to the patient. Services are not charged to the insurance company, only billed to the insurance company. Family Wellness Center cannot accept total responsibility for collecting an insurance claim, nor negotiating a disputed settlement.

_____ I also agree that this obligation shall exist regardless of the private contractual agreement between myself and any insurance carrier, attorney, or third party not signing this agreement. Financial responsibility will also include charges and services not covered by insurance, for which payment is denied through any utilization review or precertification procedures. I also understand that if I suspend/terminate my care and treatment, the fees for services rendered to me will immediately be due. In the event of default, I will pay legal interest on the indebtedness, along with collection costs and reasonable attorney fees that may be required for collection.

Subrogation and Rights of Reimbursement Agreement

_____ If I, or a covered dependent, receive benefits under my health insurance carrier, hereinafter referred to as carrier, due to an injury or illness as a result of the acts of a third party, I agree to repay the carrier any amount of money that I receive for third party of its insurer as compensation for such injuries up to the amount paid out by carrier. I understand that this includes the insurer, other agent, or if I enter into a form of settlement regarding an accident which I, or my covered dependents, are injured as a result of the acts of a third party. I will do whatever is reasonable needed to secure the carrier's rights and shall do nothing to damage such rights. I will abide by this agreement, only if my health insurance policy contains language that gives the carrier subrogation and rights of reimbursement.

Authorization for Payment of Insurance Benefits to Provider

_____ I authorize payment of the medical benefits, otherwise payable to me, to be made payable and mailed directly to Family Wellness Center for professional services rendered. No other third part, including attorney, should receive payment of my bill except this office for the remainder of this claim, unless denoted by a LOP from the attorney. It will be assumed and relied upon that the insurance carrier has agreed to and acknowledges medical coverage, and will send payments directly to this office. If payment is not rendered within 90 days upon receipt of payment from any other sources, then your account will be considered in default. Defaulted accounts are turned over to a collection agency and/or attorney for nonpayment. All charges incurred will be added to your bill along with any postage, interest or filing fees.

Returned Check Fee

_____ I understand that the fee for any returned check for insufficient funds, closed accounts, or any other ancillary concerns will be an additional $35.00 charge. This fee will be required to be paid by credit card, money order, or cash.

X-Rays

_____ I understand that there is a possibility of taking x-rays for my care. If the doctor feels that x-rays are necessary for a complete study and understanding of my condition, then I give permission.

Female Patients

_____ To the best of my knowledge, I am not pregnant.

By signing below, I acknowledge that I fully understand and accept the terms of this consent.

_____ _____

Patient Name Date

(Signature is valid for 1 year following the date above)

_____

Patient Signature

You have the right to revoke parts of this authorization in writing at any time.

New Patient Health History Form

In order to provide you the best possible care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Patient Data

First Name | Last Name | Date | Email*

* Your email will NOT be shared with any 3d parties, and is used for occasional office announcements and promotions.

Mailing address

Address | City | State | Zip

Telephone (Work) | (home) | Referred By

Age | Birth Date | Social Security # | Number of Children

Occupation | Employer

Marital Status | Spouse's Name | Spouse's Occupation

Spouse's Employer | Spouse's Health Status

Emergency Contact | Phone

Current Complaints

Nature of Injury: ☐ Automobile* ☐ Work ☐ Other

Please describe:

Date of Injury | Date symptoms appeared

Have you ever had same condition? ◯ No ◯ Yes If yes, when?

List of other practitioners seen for this injury/condition

Have you ever been under chiropractic care? ◯ No ◯ Yes

If yes, please describe

Insurance Information

Name of party responsible for payment | Phone

Do you have health insurance? ◯ No ◯ Yes Name of company

*** If an auto accident, please provide:**

Insurance Company Name | Contact Person

Phone: | Claim #

Signatures

Name of the insured _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature _____ Date _____

Spouse's or guardian's signature _____ Date _____

Medical History

Have you been treated for any conditions in the last year? ◯ No ◯ Yes

If yes, please describe

Date of last physical exam Is there a chance that you are pregnant? ◯ No ◯ Yes

Have you had X-rays taken? ◯ No ◯ Yes If Yes, where?

What medications are you taking and for what conditions (Please list dosage and amounts, etc)I

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency).

Have you ever:	No	Yes	Briefly Explain
Broken bones?	◯	◯	
Been hospitalized?	◯	◯	
Been in an auto accident?	◯	◯	
Had Sprains/Strains?	◯	◯	
Been struck unconscious?	◯	◯	
Had surgery?	◯	◯	

Family History

Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Do you experience pain every day?	◯ No	◯ Yes
Do your symptoms interfere with daily life?	◯ No	◯ Yes
Does pain wake you up at night?	◯ No	◯ Yes
Are your symptoms worse during certain times of the day?	◯ No	◯ Yes
Do changes in weather affect your symptoms?	◯ No	◯ Yes
Do you wear orthotics?	◯ No	◯ Yes
Do you take vitamin supplements?	◯ No	◯ Yes

What activities aggravate your symptoms?

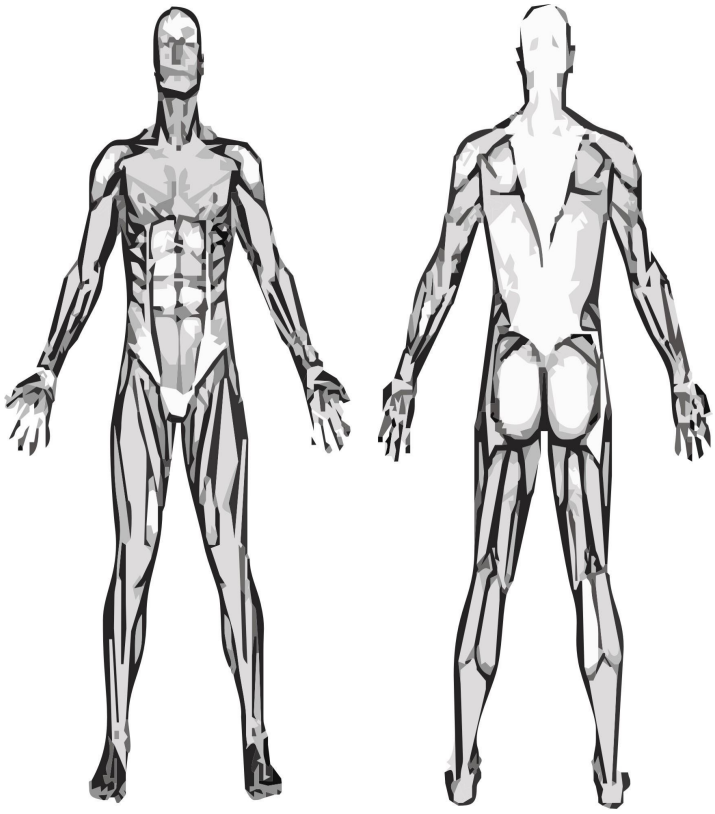
Habits	None	Light	Moderate	Heavy
Alcohol	◯	◯	◯	◯
Coffee	◯	◯	◯	◯
Tobacco	◯	◯	◯	◯
Drugs	◯	◯	◯	◯
Exercise	◯	◯	◯	◯
Sleep	◯	◯	◯	◯
Appetite	◯	◯	◯	◯
Soft Drinks	◯	◯	◯	◯
Water	◯	◯	◯	◯
Salty Foods	◯	◯	◯	◯
Sugary Foods	◯	◯	◯	◯
Artificial Sweeteners	◯	◯	◯	◯

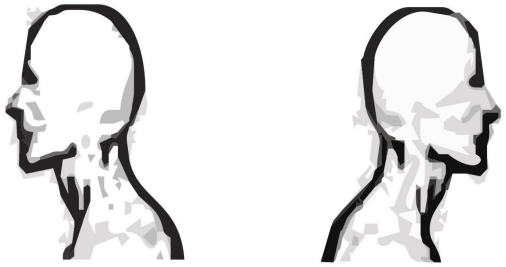
Have you ever suffered from:

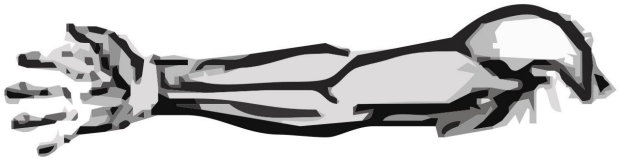
- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chest Pain/Conditions
- ☐ Cold Extremities
- ☐ Constipation
- ☐ Cramps
- ☐ Depression
- ☐ Diabetes
- ☐ Digestion Problems
- ☐ Dizziness
- ☐ Ears Ring
- ☐ Excessive Menstruation
- ☐ Eye Pain or Difficulties
- ☐ Fatigue
- ☐ Frequent Urination
- ☐ Headache
- ☐ Hemorrhoids
- ☐ High Blood Pressure
- ☐ Hot Flashes
- ☐ Irregular Heart Beat
- ☐ Irregular Cycle
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Loss of memory
- ☐ Loss of balance
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Lumps In Breast
- ☐ Neck Pain or Stiffness
- ☐ Nervousness
- ☐ Nosebleeds
- ☐ Pacemaker
- ☐ Polio
- ☐ Poor Posture
- ☐ Prostate Trouble
- ☐ Sciatica
- ☐ Shortness of breath
- ☐ Sinus Infection
- ☐ Sleep problems or Insomnia
- ☐ Spinal Curvatures
- ☐ Stroke
- ☐ Swelling of ankles
- ☐ Swollen Joints
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Venereal Disease
- ☐ Other: _____

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache **O**=Other
B=Burning **P**=Pins & Needles
N=Numbness **S**=Stabbing







Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score _____

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score _____

Activities of Daily Living Assessment

Rate your current difficulties by placing the appropriate number in the box.

If an activity does not cause pain or if pain does not affect an activity, leave box blank

1 – This activity causes some pain, but it is only a minor annoyance.

2 – This activity causes a significant amount of pain, but I can do it.

3 – I cannot perform this activity due to pain and disability.

Self-Care and Personal Hygiene

	Bathing/Showering		Making the Bed		Cooking		Doing Laundry
	Grooming Hair		Putting on Shirt		Eating		Using the Bathroom
	Washing Face		Putting on Shoes		Doing Dishes		
	Brushing Teeth		Putting on Pants		Taking out Trash		

Physical Activities

	Standing		Squatting		Bending Back		Looking Right
	Sitting		Kneeling		Bending Right		Twisting Left
	Reclining		Reaching		Bending Left		Twisting Right
	Walking		Bending Forward		Looking Left		

Functional Activities

	Carrying Small Objects		Lifting Weights off Table		Exercising Upper Body
	Carrying Large Objects		Climbing Stairs/Incline		Exercising Lower Body
	Carrying Briefcase/Purse		Pushing/Pulling while Seated		
	Lifting Object off Floor		Pushing/Pulling while Standing		

Social and Recreational Activities

	Bowling		Hunting/Fishing		Golfing		Jogging
	Biking		Horse Riding		Gardening		Competitive Sports
	Walking		Swimming		Dancing		

Difficulties with Traveling

	Driving in a car		Driving for long periods of time
	Riding as a passenger		Riding as a passenger for long periods of time

Other Activities

	Concentrating		Sleeping		Sexual Relations		Writing
	Using Computer		Listening		Reading		Studying

Patient Name: _____ **Date: _____**

Doctor Signature: _____

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain _____ **worst possible pain**

0 1 (2) 3 4 (5) 6 7 (8) 9 10

---

1 – What is your pain RIGHT NOW?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

_____

_____

_____

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.