HIPAA-Compliant Authorization For Care

1. Authorization for Consultation and Care

I hereby authorize the doctors and staff of Abundant Life Chiropractic to perform an initial consultation, physical examination, x-rays and any diagnostic procedures, if determined necessary by the attending doctor to evaluate my health condition. I understand that chiropractic care involves science, art, and philosophy of detecting and correcting spinal and joint misalignments to restore proper function and health.
I understand x-rays may be used to assist in diagnosis and determine the safest course of treatment and Female patients must inform the doctor if there is any possibility of pregnancy before radiographs are taken.

2. Release and Acknowledgement of Assignment of Benefits

I authorize payment of my insurance benefits or personal injury case be made directly to Abundant Life Chiropractic for services rendered. I understand that I am financially responsible for any charges not covered by insurance.
I authorize the release of any medical or other information necessary to process my insurance claims, including submission of information via electronic CMS-1500 forms. I acknowledge and agree to Box 12 and 13 will state "signature on file." Box 12 reads as follows: "patient's or authorized person's signature."

3. Acknowledgement of Notice of Privacy Practices (HIPAA)

I acknowledge that I have been provided with or offered a copy of Abundant Life Chiropractic's *Notice of Privacy Practices*, which explains how my health information may be used or disclosed, and how I may access that information.

4. Acknowledgement of Treatment Plans

I understand that my doctor and/or staff will review findings and recommended treatment plans with me. I acknowledge that chiropractic care and other therapeutic services offered at Abundant Life Chiropractic focused on improving function, reducing pain, and enhancing overall wellness.
I understand that the number of visits required and the duration of care will depend on my condition and response to treatment. No guarantee of results has been made to me.

5. Terms of Acceptance and Clinical Summary

By signing below, I acknowledge that I understand and agree with the policies and procedures outlined in this TERMS OF ACCEPTANCE form. By signing below, I acknowledge and certify that all the information given to the office in the INTAKE forms is true and accurate to the best of my knowledge. I choose to decline the receipt of my clinical summary after every visit.

Patient Name (Print): _____ Signature: _____

Parent/Guardian Signature (minors): _____ Relationship: _____ Date: _____

Consent for Chiropractic and Related Therapeutic Services

Purpose and Scope of Care

This consent form is intended to inform you of the nature of the healthcare services provided in this facility and the potential risks associated with those services. Your understanding and voluntary consent are essential to ensure safe and appropriate care.

Acknowledgment of Risks and Procedures

1. **General Information**
   I understand that all forms of healthcare, including chiropractic care, spinal decompression, shockwave therapy, red light therapy, massage therapy, acupuncture, and allopathic medicine, are associated with some degree of risk. The doctors and staff have explained that these risks vary depending on the procedures performed.
2. **Chiropractic Adjustment (Manipulation)**
   Chiropractic adjustments may be performed manually, with specialized tables, or using mechanical instruments. These procedures are designed to restore normal joint motion and function. A clicking or popping sound is common and indicates movement of the involved joints and bones.
3. **Supportive and Adjunctive Therapies**
   Supportive therapies may be used under the direction or supervision of the treating chiropractor. These may include diagnostic imaging, physical therapy modalities (traction, decompression, vibration, light, or electrical stimulation), soft tissue therapy, bracing, nutritional or exercise recommendations, and home care instructions.
4. **Common Reactions**
   Temporary soreness, stiffness, or mild soft tissue irritation may occur following treatment. These effects are generally short-lived. Patients are advised to report any unexpected increase in discomfort or new symptoms to the staff immediately.
5. **Less Common and Rare Complications**
   Aggravation of existing symptoms or the development of new symptoms may occasionally occur. Rare complications may include bruising, swelling, burns, or skin irritation related to physical or thermal therapies.
6. **Bone Integrity and Structural Considerations**
   Fractures or joint injuries are extremely rare but may occur, particularly in individuals with compromised bone density (e.g., osteoporosis). Special care and modified techniques are utilized for these patients.
7. **Neurological or Vascular Injury**
   Although extremely rare, nerve or vascular injury can occur in conjunction with certain types of cervical spinal adjustments. This may result in temporary or permanent neurological impairment, and in very rare cases, serious complications. The specific high-velocity neck adjustment often associated with vertebral artery stroke (extension-rotation-thrust atlas adjustment) is not performed in this office. Comprehensive examinations and imaging studies are conducted to minimize any potential risk.
8. **Prognosis and Results**
   While chiropractic and supportive therapies are often highly effective, no healthcare provider can guarantee specific outcomes. If satisfactory progress is not achieved, appropriate referral or additional diagnostic evaluation may be recommended.
9. **Healing and Recovery Expectations**
   Healing is an individual process. Depending on the nature and severity of your condition, improvement may occur gradually. In certain cases, particularly spinal disc conditions, recovery may continue for 12 to 18 months following the completion of active treatment.
10. **Opportunity for Questions**
    I acknowledge that I have been provided the opportunity to ask questions regarding my condition, the proposed treatments, associated risks, and alternative options. All of my questions have been answered to my satisfaction.

Consent and Authorization

I hereby consent to the performance of diagnostic and therapeutic procedures deemed necessary and appropriate by the attending chiropractor(s) and clinical staff under their supervision.
This consent shall remain in effect for the duration of my care in this facility, unless revoked in writing.

By typing or signing my name below, I acknowledge that I have read and fully understand the contents of this document. I voluntarily consent to care as described.

Patient Name: _____ Date: _____

Patient Signature: _____

Pre-screening Questionnaire

The following questions are vital to care in our office. Please answer All of the following questions.

Whom may we thank for referring you? □ Google □ Facebook □ Person _____ □ Other _____

By answering the following questions, you will assist us to decide which care is most suitable for you.

- Have you been injected with cortisone this month? Yes / No, if yes Date: _____
- Are you using a cardiac pacemaker? Yes / No
- Do you have cancer or a tumor? Yes / No
- Do you have a skin infection? Yes / No
- Are you pregnant or do you suspect you may be pregnant? Yes / No
- Have you ever been diagnosed with Osteoporosis? Yes / No
- Have you ever been diagnosed with Abdominal Aortic Aneurysm? Yes / No
- Are you taking blood thinners? Yes / No

What is your current weight? _____ lbs.

Have you ever been diagnosed with a bulging or herniated disc? Yes / No

Have you had an MRI of your back or neck in the last 7 years? Yes / No

MRI Clinic Name _____ Clinic Phone _____

Where and when was your last complete spinal examination, including x-rays?

Date:_____ Clinic Name _____ Clinic Phone _____

What is the number one reason you are seeking care in our office today and how is it impacting your life?

_____

Patient Name: _____ Date: _____

Patient Signature: _____

INTRODUCTION PATIENT CASE HISTORY

Today's Date: ___/___/_____

PATIENT INFORMATION

Name: *(First MI Last)* _____ **Preferred Name:** _____

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

Date of Birth: _____ **Gender:** Male Female **Social Security #:** _____

Home: _____ **Mobile:** _____ **Work:** _____ _____

Email: _____

Preferred Method of Contact: Text Email Phone - *Home, Mobile, or Work* Other: _____

***Referred By:** *(Name)* _____

Family Friend Co-Worker Doctor Other: _____

Race & Ethnicity: *(Choose up to 2)*

African American or Black
American Indian or Alaskan Native
Asian
Hispanic or Latino
Native Hawaiian or Other Pacific Islander
White
Decline

Preferred Language:

English
Spanish
Other: _____
Decline

Occupation: _____

Employer: _____

EMERGENCY CONTACT INFORMATION

Name: *(First MI Last)* _____ **Primary Care Physician:** _____

Home: _____ **Mobile:** _____ **Doctor's Phone:** _____

Relationship:

Child Parent Spouse Other: _____

FINANCIAL INFORMATION

Is today's visit the result of an accident?

No Auto Work Other _____

Will we be working with insurance? No Yes *(Details)*

Primary: _____ *ID#:* _____

Secondary: _____ *ID#:* _____

Where would you like statements sent?

Self Other *(Details below)*

Name: _____

Address: _____

Phone: _____ *Email:* _____

I have answered these questions to the best of my knowledge and certify them to be true and correct.

Patient or Guardian Signature _____ Date _____

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

Account No: _____

History of Present Illness

History of Present Illness *(Please describe)*

Major Complaint: _____ **Secondary Complaints:** _____

_____ _____

_____ _____

When did it start? ___/___/_____ **What happened?** _____

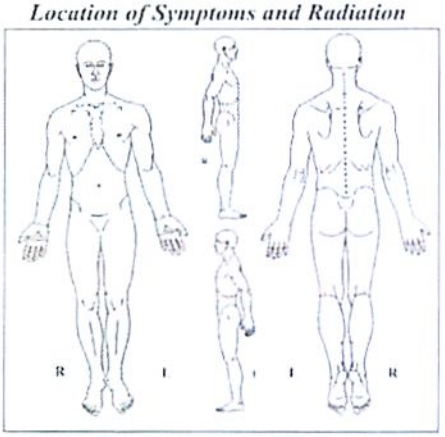
_____

Which daily activities are being affected by this condition? _____

_____

Major Complaint

Location of Symptoms and Radiation



P__ Pain T__ Tender
N__ Numb H__ Hypoesthesia
S__ Spasm

Grade Intensity/Severity:

- None (0/10)
- Mild (1-2/10)
- Mild-Moderate (2-4/10)
- Moderate (4-6/10)
- Moderate-Severe (6-8/10)
- Severe (8-10/10)

Frequency:

- Off & On
- Constant

Quality:

- Sharp
- Stabbing
- Burning
- Achy
- Dull
- Stiff & Sore
- Other: _____

Does it radiate?

No Yes *(Please indicate on drawing)*

Improves with:

- Ice
- Heat
- Movement
- Stretching
- OTC Medications: _____
- Other: _____

Worsens with:

- Sitting
- Standing/Walking
- Lying Down/Sleeping
- Overuse/Lifting
- Other: _____

Previous Treatment:

- None
- Chiropractor _____
- Medical Doctor _____
- Physical Therapy _____
- ER/Urgent Care _____
- Orthopedic _____
- Other: _____

Previous Diagnostic Testing:

- None
- X-rays _____
- MRI _____
- CT _____
- Other: _____

Women:** ***Are you pregnant?

No *Last Menstrual Period* ___/___/____

Yes *Due date* ___/___/____

Present Illness Comments:

_____

_____

_____

_____

_____

_____

Prescription Medications & Supplements: None

Yes *(List – Name, dosage, frequency)* _____

_____

_____

_____

Allergies to Medications: No known drug allergies

Yes *(List - Name and reaction)* _____

_____

_____

_____

I have answered these questions to the best of my knowledge and certify them to be true and correct.

Patient or Guardian Signature _____ Date _____

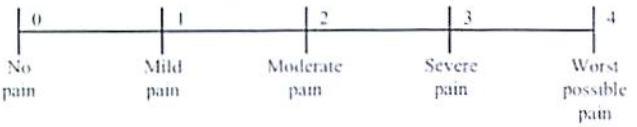
Print Name: *(First MI Last)* _____

Functional Rating Index

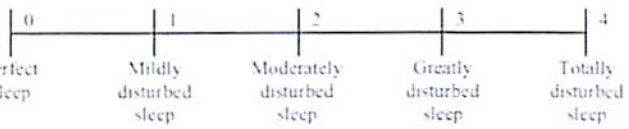
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** has affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now**.

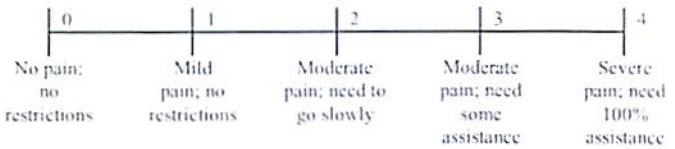
1. Pain Intensity



2. Sleeping

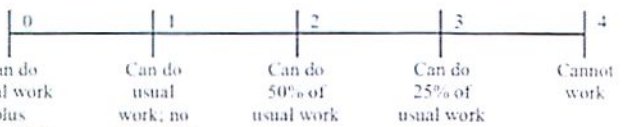


3. Personal Care (washing, dressing, etc.)

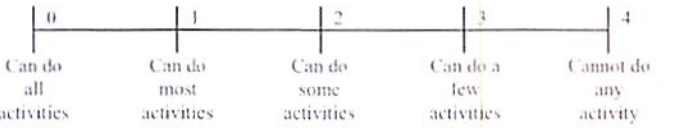


4. Travelling (driving, etc.)

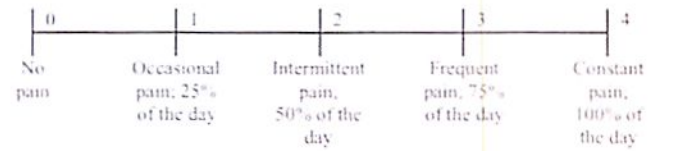
5. Work



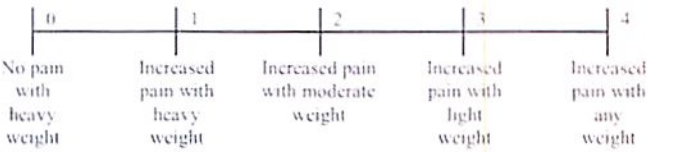
6. Recreation



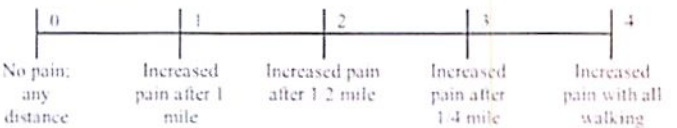
7. Frequency of Pain



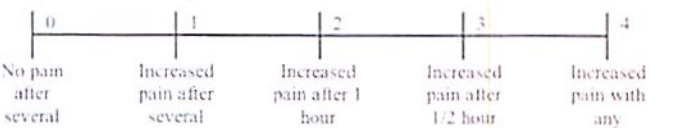
8. Lifting



9. Walking



10. Standing



Patient's Signature _____ Date _____

For Office Use Only:

Practitioner ID#: _____

Total Score _____ / 40

Clinical Diagnosis Codes:

Patient ID#: _____