# WELCOME BACK TO
# CHIROPRACTIC WELLNESS CONNECTION

In order to update our records and evaluate your present condition as thoroughly as possible, we ask that you please complete this form. Thanks!

Today's Date:_____

Name:_____ Preferred to be called:_____

Address:_____City/state:_____ Zip:_____

Home Phone #:_____ Work #:_____ Cell:_____

DOB:_____ Age:_____ Current Insurance Company:_____
*A copy of your insurance card will be needed.*

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Describe your condition: _____

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Sharp Shooting Aching Throbbing Burning Numbness Weak
Constant Frequent Comes & Goes Getting worse Wellness Checkup

What makes it better?_____

What makes it worse?_____

Is this condition interfering with Work___ Sleep___ Daily Routine___ Other:_____
If so how:_____

Other doctors/ treatment for this condition: _____

Since you were last here have you been involved in any of the following:

| | | | If yes to any of these, please explain: |
|---|---|---|---|
| Automobile Accident | No___ | Yes___ | Details:_____ |
| Personal Injury | No___ | Yes___ | Details:_____ |
| Workers Comp. | No___ | Yes___ | Details:_____ |
| Surgery | No___ | Yes___ | Details:_____ |
| Seen by other chiropractor | NO___ | Yes___ | Details:_____ |
| Other Injury | NO___ | Yes___ | Details:_____ |

OTHER:_____

_____

Signature:_____

# Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

**CHIROPRACTIC TREATMENT** or management of conditions almost always includes the chiropractic adjustment, a specific type of joint manipulation performed by hand or instrument. Like most healthcare procedures, the chiropractic adjustment carries with it some risk and results are not guaranteed. Unlike many such procedures, the serious risks associated with the chiropractic adjustment are extremely rare. The following are the known risks with chiropractic treatment:

**Temporary soreness, muscle spasm, or increased symptoms or pain:** it is not uncommon for patients to experience temporary soreness, muscle spasm or increased symptoms or pain after the first few treatments

**Dizziness, nausea, flushing:** These symptoms are relatively rare. It is important to notify the chiropractor if you experience these symptoms during or after your care.

**Fractures:** When patients have underlying conditions and/or treatments that weakens bones, they may be susceptible to fracture. It is important to notify your chiropractor if you have been diagnosed with a bone weakening disease, condition or medical treatment. If your chiropractor detects any such condition while you are under care, you will be informed and your treatment plan will be modified to minimize risk of fracture.

**Disc herniation or prolapse:** Spinal disc conditions like bulges or herniations may worsen even with chiropractic care. It is important to notify your chiropractor if symptoms change or worsen.

**Stroke:** A certain extremely rare type of stroke has been associated with chiropractic care. Although there is an association between this type of stroke and chiropractic treatment, there is also an association between this type of stroke and primary care medical visits. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Patients who experience this condition often, but not always, present to their chiropractor or medical doctor with neck pain and headache.

**Other possible risks:** Other possible risks include but are not limited to bruising, disruption of internal medical devices, dislocations, and/or sprains and strains. If any of these conditions or symptoms occur, notify your chiropractor immediately.

It is important to know that it is not possible to consider every possible complication to care.

**ACUPUNCTURE** treatment is form of therapy in which fine needles are inserted into specific points on the body. Acupuncture is generally very safe and serious side effects are very rare. Acupuncture may be contraindicated on certain patients so notify chiropractor before treatment if you have any of the following: are pregnant, have a pacemaker or other electrical implant, bleeding disorder, blood borne pathogens, or are taking anticoagulants or any other medications. It is important to not move during the insertion, retention or removal of the needles.



Pt Initals:____

The following are known risks with **acupuncture care**:

**Drowsiness** occurs after treatment in a small number of patients, and, if effected, you are advised not to drive.

**Minor bleeding, bruising, and/or pain** may occur during or after acupuncture treatment.

**Temporary worsening of symptoms, numbness and tingling, and/or muscle contractions** may occur.

**Dizziness or fainting** can occur in certain patients particularly in the first treatment.

**Infection** is another possible risk, although the chiropractor uses sterile, single use, disposable needles.

It is important to know that it is not possible to consider every possible complication to care.

It is also important that you understand there are treatment options available for your condition other than chiropractic and acupuncture procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over the counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and healthcare as you see fit.

I have read, or had read to me, the above consent. I have discussed or been given the opportunity to discuss any questions or concerns with my chiropractor and have had these answered to my satisfaction prior to my signing this document. I acknowledge that no guarantee can be given as to the results or outcome of my care. I have made my decision voluntarily and freely. I hereby give my consent to the performance of diagnostic tests, procedures and chiropractic treatment, acupuncture treatment and physical modalities recommended by my chiropractor and/or management of my conditions.

Patient Name: _____ Signature: _____ Date:_____

Parent or Guardian: _____ Signature: _____ Date:_____

Witness Name: _____ Signature: _____ Date:_____

**Chiropractic Wellness Connection**
**410 E. Elm St.**
**Canton, IL 61520**

## Consent to Examination and Treatment of Minor

I, the undersigned, do hereby authorize Dr. Jennifer C. Daniel-Price, D.C., Dr. Abby Sherwood, D.C., and other licensed chiropractic physicians and assistants employed by Chiropractic Wellness Connection under their supervision, to perform examination, diagnostic tests, diagnosis and render necessary treatment as deemed necessary by the doctor to my minor child:

Name of minor: _____

Further, I state and agree that in no manner or form have I been promised a cure of any conditions or diseases. I understand that my child's care may involve the making of judgments based on the facts known to the doctor at this time. I authorize the doctor to exercise judgment during the course of any procedure which he/she feels at the time would be in my child's best interests based on known facts.

I hereby affirm that I have the legal right to select and authorize health care services for the minor child named above. If for any reason, my status of authorization changes, I will notify this office immediately.

I have read and agree to all of the above statements and give consent to examination and treatment of said minor.

_____ _____
Date Printed Name of Guardian

_____ _____
Relationship to patient Signature of Guardian

### PAYMENT INFORMATION

- o I currently have BCBS. I give full permission to Chiropractic Wellness Connection and its employees to do and release all that is necessary to have the insurance payments covered. I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I do know that I am ultimately responsible for any balance on my account.
  *CWC will need a copy of your insurance card and all of the insured's information in order to bill today.
- o I have other insurance and would like a receipt that I can send to my insurance company myself for possible reimbursement. I know that I am responsible for any balance on my account.
- o I have an automobile accident or other personal injury account and claim that has been opened and is current. I am seeking treatment for injuries directly related from this accident. I know that I am responsible for any balance on my account.
- o I do <u>not</u> have insurance benefits and will be paying as a cash patient. I am fully responsible for my account. Responsible party (if other than patient or if patient is a minor _____

I hereby authorize the staff to perform any necessary services needed for proper diagnosis and treatment procedures. I further acknowledge this form was completed correctly to the best of my knowledge and understand that it is my responsibility to inform this office of any changes.

Guardian Signature:_____Date:_____

Jennifer Daniel-Price, D.C.
Abby Sherwood, D.C.

Chiropractic Wellness Connection
410 E. Elm St. Canton, IL 61520
309-647-7490 ph

# Communication Regarding Confidential Information

In order for Chiropractic Wellness Connection to keep communication regarding your health information confidential, please complete this form:

May we contact you at home? Yes _____ No _____ Phone number: _____

May we contact you at work? Yes _____ No _____ Phone number: _____

May we contact you on your cell phone? Yes _____ No _____ Phone Number: _____

I prefer to be contacted: At Home _____ At work _____ On my Cell _____

May we contact you by e-mail? Yes _____ No _____ E-mail: _____

May we contact you with appointment reminders? Yes _____ No _____
If yes, how would you like your reminder? Text to Cell phone _____ E-mail _____
If text to cell phone, who is your cell phone provider? (Verizon, Sprint, etc) _____

May we leave a message with another party? Yes _____ No _____
If yes, please list authorized party to receive protected health information on your behalf:

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Please list any other special requests regarding your health information: _____

_____

I, the undersigned, herby acknowledge that by signing this Consent:

1. I am aware that the Practice's Privacy Notice is available to me upon request. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carryout health care operations. The Privacy Notice is also available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to signing this Consent.
2. The practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable laws.
3. The Practice's "Notice of Privacy Practices" is provided at 410 E. Elm St., Canton, IL 61520. I may also request a copy from this office at any time directly from the office or via US Mail.
4. This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information.

Patient's Name (please print): _____

Signature: _____ Date: _____

If you are not the patient, please specify your relationship to the patient: _____