



# INFINITY WELLNESS CENTER

INFINITE POSSIBILITIES

## PATIENT APPLICATION FORM

WELCOME and THANK YOU for applying as a patient in our clinic. We are a very unique team specializing in researched-based spinal and postural rehabilitation. These methods have enabled our patients to achieve their optimal health; even when many other systems have failed. Because of this specialized approach, we may not accept you as a patient until we are absolutely certain we know the cause of your condition, that we can perform the necessary tests to establish an optimal rehab program for you, and are completely confident we can help you recover your health. Please know if we do accept you as a patient, we will then make specific recommendations based upon our understanding that your health will become your TOP PRIORITY. Thank you again for applying as a patient in our clinic.

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***PATIENT NAME***

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***DATE COMPLETED***

## Patient Information

Name: \_\_\_\_\_ (Age) \_\_\_\_\_ Gender: M F  
Home Address: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_  
Email Address: \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_  
Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Marital Status: S M D W  
Occupation: \_\_\_\_\_ Employer Name: \_\_\_\_\_  
Spouse's Name: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_  
Spouse's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
How were you referred to this office? \_\_\_\_\_

## Purpose For This Visit

Reason for this visit: \_\_\_\_\_

Is this related to an accident or specific injury (other than auto or work-related)\*?  Yes  No If yes, when: \_\_\_\_/\_\_\_\_/\_\_\_\_

*\*If your symptoms are the result of an auto accident or work-related injury, please ask the front-desk person for the corresponding application.*

Describe: \_\_\_\_\_

**Please use the *General Symptoms Chart* on the next page to provide a detailed notation of your symptoms.**

When did these symptoms begin? \_\_\_\_/\_\_\_\_/\_\_\_\_ Are they:  Constant  Intermittent  Activity-related

Are they getting worse?  Yes  No Do they interfere with:  Work  Sleep  Hobbies  Daily Routine

Explain: \_\_\_\_\_

What activities aggravate your symptoms? \_\_\_\_\_

Is there anything that relieves your symptoms?  Yes  No If yes, explain: \_\_\_\_\_

Have you experienced these symptoms before (if not accident/injury related)?  Yes  No

If yes, explain: \_\_\_\_\_

Have you been treated for this?  Yes  No When were you last treated? \_\_\_\_/\_\_\_\_/\_\_\_\_

Who did you see? \_\_\_\_\_

What treatment was performed? \_\_\_\_\_

How did you respond? \_\_\_\_\_

## Experience with Chiropractic

Have you seen a Chiropractor before?  Yes  No Who? \_\_\_\_\_

Reason for visit(s): \_\_\_\_\_

Did your previous chiropractor take 'before' and 'after' x-rays?  Yes  No What was the diagnosis? \_\_\_\_\_

Did he or she recommend a specific course of treatment?  Yes  No Did they recommend a Home Health Care program?  Yes  No

If yes, what? \_\_\_\_\_ How long were you treated? \_\_\_\_\_ Last treatment: \_\_\_\_/\_\_\_\_/\_\_\_\_

How did you respond? \_\_\_\_\_

Are you aware of any poor posture habits?  Yes  No Is there any history of spinal problems in your family?  Yes  No

If yes, explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# GENERAL SYMPTOMS CHART

Please use the following notations on the figures below to indicate the type and location of your symptoms, as it relates to the purpose of your visit today.

A = ACHE

B = BURNING

P = PINS & NEEDLES

G = STABBING

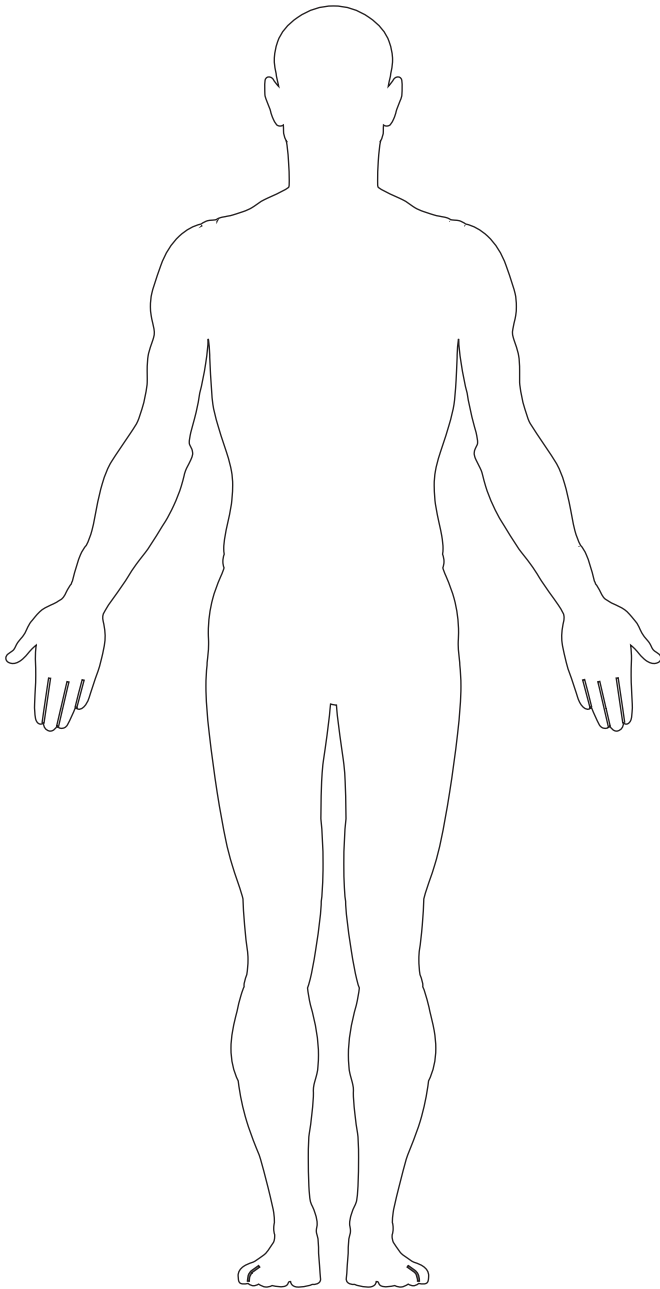
M = SPASMS

F = STIFFNESS

N = NUMBNESS

T = TINGLING

O = OTHER



**FRONT**



**BACK**

If you marked "O" for Other on any part, please explain below:

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## Health & Lifestyle

Do you exercise?  Yes  No How often? \_\_\_\_\_ day(s) per week; Other: \_\_\_\_\_

What activities?  Walking  Running/Jogging  Weight Training  Cycling  Yoga  Pilates  Swimming  Other: \_\_\_\_\_

Do you smoke?  Yes  No How much? / How often? \_\_\_\_\_

Do you drink alcohol?  Yes  No How much? / How often? \_\_\_\_\_

Do you drink coffee?  Yes  No How much? / How often? \_\_\_\_\_

Do you take any supplements (i.e. vitamins, minerals, herbs)? \_\_\_\_\_

If yes, please list: \_\_\_\_\_

## Health Conditions

Your spine is the foundation of health and core strength in your body. Shifts in the vertebrae or sections of the spine will spread ultimately causing weakness and distortion to ALL the areas of the spine. These distortions are reflected in abnormal posture. Research shows abnormal posture leads to chronic pain, disease and possibly a shortened life span.<sup>1</sup> Please answer the following questions accurately so we may determine the full extent of your condition.

### CERVICAL SPINE (NECK)

Misalignment of the individual vertebrae or distortion of the complete cervical curve (neck) originating in the neck or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

**Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.**

\_\_\_\_ Neck Pain

\_\_\_\_ Headaches

\_\_\_\_ Sinusitis

\_\_\_\_ Pain in shoulders/arms/hands

\_\_\_\_ Dizziness

\_\_\_\_ Allergies/Hay fever

\_\_\_\_ Numbness/tingling in arms/hands

\_\_\_\_ Visual disturbances

\_\_\_\_ Recurrent colds/Flu

\_\_\_\_ Hearing disturbances

\_\_\_\_ Coldness in hands

\_\_\_\_ Low Energy/Fatigue

\_\_\_\_ Weakness in grip

\_\_\_\_ Thyroid conditions

\_\_\_\_ TMJ/Pain/Clicking

Please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### THORACIC SPINE (UPPER BACK)

Misalignment of the individual vertebrae or distortion of the upper thoracic curve (upper back) originating in the upper back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

**Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.**

\_\_\_\_ Heart Palpitations

\_\_\_\_ Recurrent Lung Infections/Bronchitis

\_\_\_\_ Heart Murmurs

\_\_\_\_ Asthma/Wheezing

\_\_\_\_ Tachycardia

\_\_\_\_ Shortness Of Breath

\_\_\_\_ Heart Attacks/Angina

\_\_\_\_ Pain On Deep Inspiration/Expiration

Please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

1. Postural and Degenerative Kyphosis: Freeman JT. Posture in the Aging and Aged body. JAMA 1957, Oct 19: 843-846.

## Health Conditions *continued...*

### THORACIC SPINE (MID BACK)

Misalignment of the individual vertebrae or distortion of the mid thoracic curve (mid back) originating in mid back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

**Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Mid Back Pain   | <input type="checkbox"/> Nausea           | <input type="checkbox"/> Diabetes                   |
| <input type="checkbox"/> Pain in Ribs/Chest  | <input type="checkbox"/> Ulcers/Gastritis | <input type="checkbox"/> Hypoglycemia/Hyperglycemia |
| <input type="checkbox"/> Indigestion/Heartburn   | <input type="checkbox"/> Reflux           |   |
| <input type="checkbox"/> Tired/Irritable after eating or when not having eaten for a while |   |   |

Please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### LUMBAR SPINE (LOW BACK)

Misalignment of the individual vertebrae or distortion of the lumbar curve (low back) originating in the low back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

**Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Pain in hips/legs/feet         | <input type="checkbox"/> Weakness/injuries in hips/knees/ankles      | <input type="checkbox"/> Low back pain         |
| <input type="checkbox"/> Numbness/tingling in legs/feet | <input type="checkbox"/> Recurrent bladder infections                | <input type="checkbox"/> Coldness in legs/feet |
| <input type="checkbox"/> Frequent/difficulty urinating  | <input type="checkbox"/> Muscle cramps in legs/feet                  | <input type="checkbox"/> Sexual dysfunction    |
| <input type="checkbox"/> Constipation/Diarrhea          | <input type="checkbox"/> Menstrual irregularities/cramping (females) |  |

Please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### OTHER

Please list any health conditions not mentioned: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any medications (include name, dose, for what condition, and how long you've been taking it): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any surgeries (include type of surgery and date it was performed): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Family Health History

Have any of your family members ever been diagnosed with the following (*please indicate "Y" for You, and "O" for Other than you, or both if applicable*):

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Neurological Problems	<input type="checkbox"/> Lung Disease
<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Stroke	<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Cancer	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Metal Implants	<input type="checkbox"/> Infectious Disease	<input type="checkbox"/> Gall Bladder
<input type="checkbox"/> Broken bones/fractures	<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Tonsillectomy	<input type="checkbox"/> Hernia
<input type="checkbox"/> Pneumonia/Bronchitis	<input type="checkbox"/> Polio	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Anemia
<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Chicken Pox/Shingles	<input type="checkbox"/> Mumps	<input type="checkbox"/> Measles
<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Small Pox	<input type="checkbox"/> Influenza	<input type="checkbox"/> Pleurisy
<input type="checkbox"/> Blood Sugar Problems	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Eczema/Psoriasis	<input type="checkbox"/> Lumbago
<input type="checkbox"/> Other: _____			

## Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## Authorization of Care

I authorize and agree to allow the doctor and/or his/her designated staff to take x-rays and work with my spine or the spine of the charge I represent through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal bio-mechanical and neurological function.

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.

The Doctor and/or his/her staff will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another healthcare practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.

I also clearly understand that if I do not follow the doctors and/or staff's specific recommendations at this clinic that I will not receive the full benefit from these programs; and that if I terminate my care prematurely that all fees incurred will be due and payable at that time.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient's Name Printed \_\_\_\_\_

If patient is a legal charge of limited capacity requiring guardianship for treatment, please complete the following:

Date Guardianship Awarded \_\_\_\_\_ County, State of Guardianship \_\_\_\_\_

I hereby authorize the doctor to administer care as deemed necessary to my charge as appointed to by the courts.

Guardian Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## In Case of Emergency

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Work Phone ( ) \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_

Cell Phone ( ) \_\_\_\_\_

**ACTIVITIES OF DAILY LIVING/SYMPTOMS/MEDICATIONS**

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_ HR# \_\_\_\_\_

Daily Activities: Effects of current conditions on performance

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Bending	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Carrying	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Climbing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Concentrating	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dancing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Doing Chores	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Doing Computer Work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dressing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Gardening	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Lifting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Performing Sexual Activity	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Playing Sports	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Pushing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Reading	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Recreation Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Rolling Over	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Running	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Shoveling	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sitting to Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sleeping	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Watching TV	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Working	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform

# Quadruple Visual Analogue Scale

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_ HR# \_\_\_\_\_

**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	

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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:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Doctor's Signature

\_\_\_\_\_  
Date Reviewed



# Infinity Wellness Center

## NOTICE of OFFICE POLICIES

### Welcome to Infinity Wellness Center!

As a potential new patient, we feel it is important that you understand our office policies regarding, how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return. Once you have read our Notice of Office Policies, if you have any questions or any of these policies are unclear to you, and you would like further explanation before submitting your Application for Care, please let our front desk know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone's best interests to provide potential new patients as much information as possible about how the doctors at this office practice chiropractic so that an informed decision can be made as to whether they wish to become a patient.

Over time, individuals who are accepted, as patients at this office, gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open bay area, patients have a unique opportunity to observe firsthand the positive results that are achieved and the benefits derived from being under chiropractic care. This knowledge and awareness reaps a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about.

**□ PATIENT PRIVACY** – Since the majority of patient care takes place in an open bay area it is important to understand that any conversations you have with the doctor can be overheard by other patients. In order to maintain patient privacy it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter you wish to discuss please let us know, and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.

**□ YOUR CARE** – When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at Infinity Wellness Center is rendered primarily to minimize and reduce subluxations, which are a major interference to the expression of the body's innate wisdom. The doctors use a myriad of techniques to accomplish this goal, including but not limited to Maximized Living Techniques. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through two distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving your overall health.

**□ FIRST THINGS FIRST** – Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do in addition to being adjusted to maintain their health for a lifetime.

**□ PATIENT'S REPORT OF FINDINGS** – To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your first adjustment, you will be scheduled for a 'Doctor's Report of Findings'. The information you receive at this appointment will be both informative and clinically relevant to your case; therefore attendance is required for individuals who wish to become new patients of this practice. Because the results of your x-rays and all examinations as well as the doctors' recommendations for care will be discussed at that time, we strongly urge new patients to invite their spouse or significant other to attend. We know from experience that when a patient's family understands the goals and objectives of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options.

# Infinity Wellness Center

## NOTICE of OFFICE POLICIES

Note: Patient retains the above Notice of Office Policies and Infinity Wellness Center retains the signature sheet.

I hereby acknowledge receiving a copy of the practice's Notice of Office Policies a two-page document, the first page of which I have read and retained. This second page is recognized by me as the signature page and will be retained by the practice as evidence of my receiving and understanding this Notice of Office Policies. I further acknowledge that a qualified member of the staff to my complete satisfaction has answered any concerns regarding these office policies as well as all my questions.

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
DOB

\_\_\_\_\_  
HR#

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness's Signature

\_\_\_\_\_  
Date

# Infinity Wellness Center

## PATIENT PRIVACY NOTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **Personal Health Information**. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Once you have read this notice, please sign the next page, and return only the signature page (page 4) to our front desk receptionist. Keep this page for your records.

### PERMITTED DISCLOSURES:

1. Treatment purposes — discussion with other health care providers involved in your care
2. Inadvertent disclosures — open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes — to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes — to process a claim or aid in investigation.
5. Emergency — in the event of a medical emergency we may notify a family member.
6. For public health and safety — in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To government agencies or law enforcement — to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons — discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders — **we may call your home and leave messages** regarding a missed appointment or apprise you of changes in practice hours or upcoming events.
11. Change of ownership — in the event this practice is sold, the new owners would have access to your PHI.

### YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive Detail Privacy Notice.
3. To request mailings to an address different than residence.
4. To request restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). X-rays are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

### COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Kelly Wampler at 512-248-9235. If she is unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights  
200 Independence Ave. SW  
Room 509F HHH Building  
Washington DC 20201

# Infinity Wellness Center

## PATIENT PRIVACY NOTICE

I have received a copy of Infinity Wellness Center's Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this Patient Privacy Notice at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this notice is available to me. At this time, I do not have any questions regarding my rights or any of the information I have received.

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
DOB

\_\_\_\_\_  
HR#

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness's Signature

\_\_\_\_\_  
Date

# Infinity Wellness Center

## INFORMED CONSENT

**REGARDING:** Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Infinity Wellness Center have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

\_\_\_\_\_  
Patient's Signature (or Authorized Person)

\_\_\_\_\_  
Date Completed

\_\_\_\_\_  
Witness Initials

**REGARDING:** X-rays/Imaging Studies:

**FEMALES ONLY:** please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

The first day of my last menstrual cycle was on \_\_\_ / \_\_\_ / \_\_\_ .

I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

\_\_\_\_\_  
Patient's Signature (or Authorized Person)

\_\_\_\_\_  
Date Completed

\_\_\_\_\_  
Witness Initials