



INFINITY **WELLNESS** CENTER
INFINITE POSSIBILITIES

**PATIENT APPLICATION FORM:
CHILD**

WELCOME and THANK YOU for trusting us with your child/children applying as patient(s) in our clinic. We are a very unique team specializing in researched, evidence-based, spinal pediatric adjusting and postural rehabilitation that has helped infants, young children, and even teenagers with early onset to advanced spinal distortion and injuries known to cause developmental and lifelong health problems. Because of this specialized approach, we may not accept your child as a patient until we are absolutely certain we know the cause of their condition; perform the necessary tests to determine the optimal program of correction, and we are completely confident you and your child place their health as a TOP PRIORITY. At that time we will make specific recommendations. Thank you again for giving your child the opportunity to apply as a patient.

PATIENT NAME

DATE COMPLETED

Patient Information

Name: _____ (Age) _____ Gender: M F
Home Address: _____ Birth Date: ____/____/____
City, State, Zip: _____ Cell Phone: () _____
Name of Mother/Guardian: _____ Home Phone: () _____
Birth Date: ____/____/____ (Age) _____ Marital Status: S M D W Work Phone: () _____
Home Address (if different): _____ Cell Phone: () _____
City, State, Zip: _____ Email: _____
Employer Name: _____ Occupation: _____
Name of Father/Guardian: _____ Home Phone: () _____
Birth Date: ____/____/____ (Age) _____ Marital Status: S M D W Work Phone: () _____
Home Address (if different): _____ Cell Phone: () _____
City, State, Zip: _____ Email: _____
Employer Name: _____ 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 child's symptoms are the result of an auto accident or work-related injury, please ask the front-desk person for the corresponding application.*
Describe incident or reason for onset of symptoms: _____

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

When did these symptoms begin? ____/____/____ Are they: Constant Intermittent Activity-related
Are they getting worse? Yes No Do they interfere with: School Sleep Hobbies/Play Daily Routine
Explain: _____

What activities aggravate these symptoms? _____
Is there anything that relieves your symptoms? Yes No If yes, explain: _____
Has your child experienced these symptoms before (if not accident/injury related)? Yes No
If yes, explain: _____

Has your child been treated for this? Yes No When was the last treatment? ____/____/____
Name of treating practitioner/facility? _____
What treatment(s) was performed? _____

How did your child respond? _____

GENERAL SYMPTOMS CHART

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

A = ACHE

B = BURNING

P = PINS & NEEDLES

G = STABBING

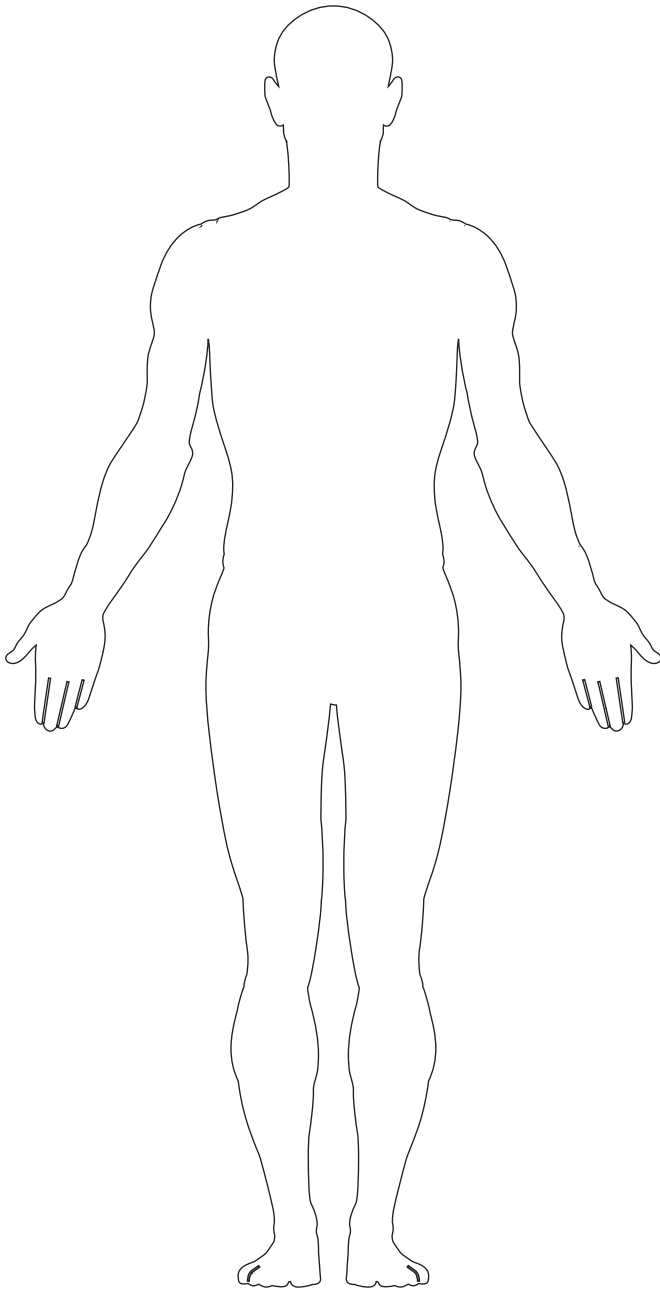
M = SPASMS

F = STIFFNESS

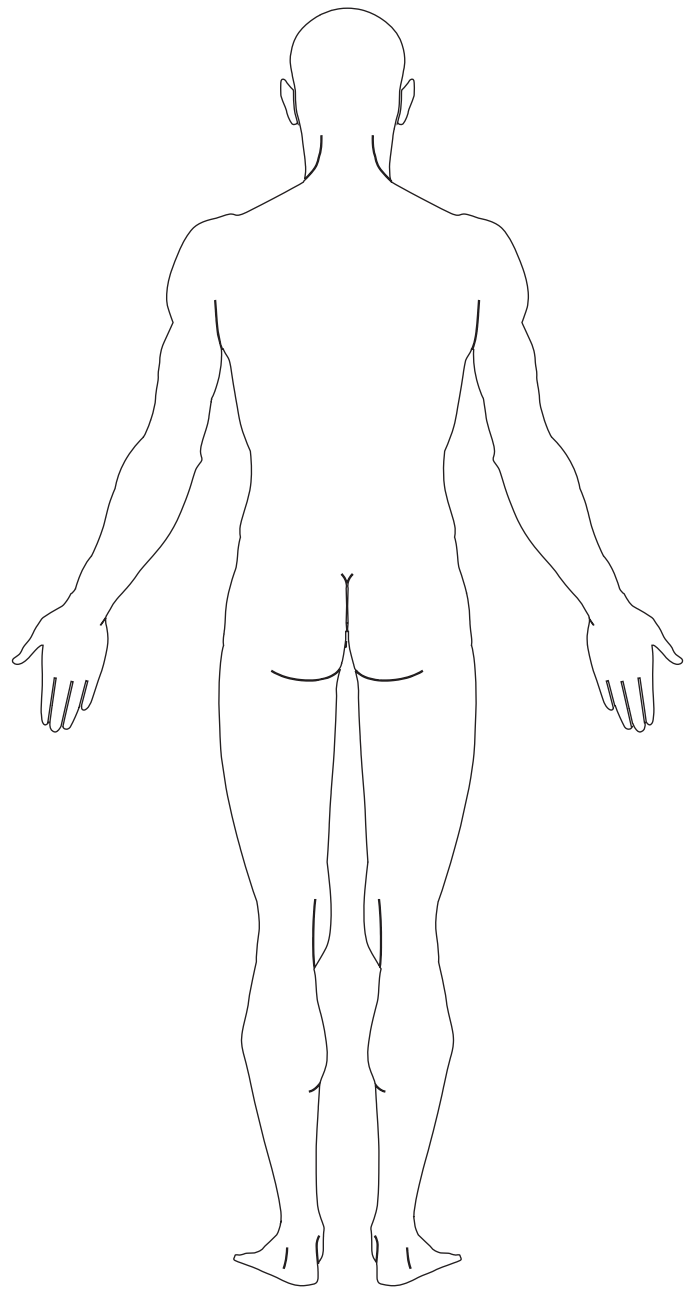
N = NUMBNESS

T = TINGLING

O = OTHER



FRONT



BACK

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

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.¹ Please answer the following questions accurately so we may determine the full extent of your child's condition.

HISTORY OF TRAUMA

The below-listed traumas may lead to misalignment of the individual vertebrae, soft tissue injury to the supportive structures of the spine, as well as shifts and distortions in whole curves and sections of the spine. Please check any of the following if your child has experienced such (*if you check an item with an asterisk, please offer a detailed explanation*):

- Fell from a height of two (2) feet or more as an infant
- Experienced a fall that left a bruise or lump on their head or other resulting trauma*
- Rough shaking as an infant
- Were involved in a car accident (*if you check this item, please ask the front desk person for the corresponding form*)
- Experience broken bones or debilitating injuries*
- Difficult Birth (see below)

Explanation of (*) item(s): _____

BIRTH EXPERIENCE:

How long was labor? _____

Describe any complications: _____

Type of delivery: Vaginal C-Section Vacuum Extraction Forceps Assistance

VACCINATION HISTORY

What vaccinations has your child received (please note at what age and where each was received):

1. _____ Age: _____ Mos. Yrs. Where received: _____
2. _____ Age: _____ Mos. Yrs. Where received: _____
3. _____ Age: _____ Mos. Yrs. Where received: _____
4. _____ Age: _____ Mos. Yrs. Where received: _____
5. _____ Age: _____ Mos. Yrs. Where received: _____

Please check any of the following responses your child experienced as a result of a vaccination (please indicate which vaccination caused the condition by writing the corresponding number next to that condition).

- | | | |
|---|---|--|
| <input type="checkbox"/> Swelling, redness, heat/hardness of site | <input type="checkbox"/> Body rash or hives | <input type="checkbox"/> High fever (over 103 degrees) |
| <input type="checkbox"/> High-pitched screaming | <input type="checkbox"/> Extreme sleepiness or unresponsiveness | <input type="checkbox"/> Body twitching or paralysis |
| <input type="checkbox"/> Breathing problems (asthma, etc.) | <input type="checkbox"/> Excessive bleeding or anemia | <input type="checkbox"/> Head banging |
| <input type="checkbox"/> Excessive diarrhea or chronic constipation | <input type="checkbox"/> Loss of memory/foggy state | <input type="checkbox"/> Muscle weakness |
| <input type="checkbox"/> Chronic ear or respiratory Infections | <input type="checkbox"/> Vision or hearing disturbances | <input type="checkbox"/> Joint pain |
| <input type="checkbox"/> Crossing of eyes | <input type="checkbox"/> Seizures | <input type="checkbox"/> Other (please explain) |

Explanation(s): _____

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

Health Conditions *continued...*

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. Has your child 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"/> Neck Pain | <input type="checkbox"/> Headaches | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Pain in shoulders/arms/hands | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Allergies/Hay fever |
| <input type="checkbox"/> Numbness/tingling in arms/hands | <input type="checkbox"/> Visual disturbances | <input type="checkbox"/> Recurrent colds/Flu |
| <input type="checkbox"/> Hearing disturbances | <input type="checkbox"/> Coldness in hands | <input type="checkbox"/> Low Energy/Fatigue |
| <input type="checkbox"/> Weakness in grip | <input type="checkbox"/> Thyroid conditions | <input type="checkbox"/> TMJ/Pain/Clicking |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Flu/Stomach disorders |
| <input type="checkbox"/> Sore throats | <input type="checkbox"/> Learning disabilities | <input type="checkbox"/> Hyperactivity/ADD |
| <input type="checkbox"/> Auto-Immune Diseases | <input type="checkbox"/> Other (please explain) | |

Explanation(s): _____

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. Has your child 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"/> Heart Palpitations | <input type="checkbox"/> Heart Murmurs | <input type="checkbox"/> Asthma/Wheezing |
| <input type="checkbox"/> Shingles | <input type="checkbox"/> Shortness Of Breath | <input type="checkbox"/> Tachycardia (fast heart beat) |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Pain On Deep Inspiration/Expiration | <input type="checkbox"/> Other (please explain) |
| <input type="checkbox"/> Recurrent Lung Infections/Bronchitis/Pneumonia | | |

Explanation(s): _____

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. Has your child 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 |
| <input type="checkbox"/> Indigestion/Heartburn | <input type="checkbox"/> Reflux | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Liver problems | <input type="checkbox"/> Spleen problems | <input type="checkbox"/> Other (please explain) |
| <input type="checkbox"/> Tired/Irritable after eating or when not having eaten for a while | | |

Explanation(s): _____

Health Conditions *continued...*

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. Has your child 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 your 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"/> Constipation/Diarrhea |
| <input type="checkbox"/> Menstrual irregularities/cramping (females) | <input type="checkbox"/> Other (please explain) | |

Explanation(s): _____

OTHER

Please list any health conditions not mentioned: _____

Please list any medications (include name, dose, for what condition, and how long your child has 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? **If so, please indicate "P" for your child (patient), and "O" for Other than your child, or both if applicable (Items marked with an asterisk, please offer a detailed list or explanation):**

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> ADD | <input type="checkbox"/> Allergies/Hay fever* | <input type="checkbox"/> Anemia | <input type="checkbox"/> Appendectomy |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Blood sugar problems |
| <input type="checkbox"/> Broken bones/fractures | <input type="checkbox"/> Cancer | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Chicken pox/shingles |
| <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Crohn's/Colitis | <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Eczema | <input type="checkbox"/> Eczema/Psoriasis | <input type="checkbox"/> Epilepsy/seizures |
| <input type="checkbox"/> Fetal drug exposure | <input type="checkbox"/> Food allergies* | <input type="checkbox"/> Gall bladder | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> HIV | <input type="checkbox"/> Infectious disease | <input type="checkbox"/> Influenza |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Lumbago | <input type="checkbox"/> Lung disease |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Metal implants | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Neurological problems | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Pneumonia/Bronchitis | <input type="checkbox"/> Polio | <input type="checkbox"/> Rash | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Seizure disorder | <input type="checkbox"/> Sickle cell anemia | <input type="checkbox"/> Small Pox |
| <input type="checkbox"/> Spinal Bifida | <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Whooping cough | <input type="checkbox"/> Other* |

Explanation of (*) item(s): _____

Experience with Chiropractic

Has your child seen a Chiropractor before? Yes No Who? _____

Reason for visit(s): _____

Did the 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 was your child treated? _____ Last treatment: _____ / _____ / _____

How did your child respond? _____

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

If yes, explain: _____

Pregnancy Release

This is to certify that to the best of my knowledge that my child is 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: _____ / _____ / _____

Guardian 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 not your biological child, but a legal charge 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	

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