Registration and History

Patient's Name: _____ Today's Date: _____

Infinity Wellness and Chiropractic

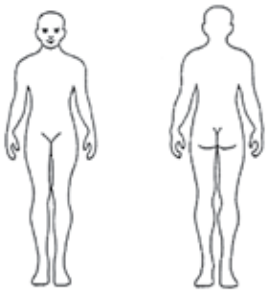
1 Patient Condition

Chief Complaint _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling:



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ NA

Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down ☐ NA

2 Health History

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy
☐ Chiropractic Services ☐ None ☐ Other

Name and address of other doctor(s) who have treated you for your condition: _____

Date of Last: Physical Exam _____ Spinal X-ray _____ Blood Test _____
Spinal Exam _____ Chest X-ray _____ Urine Test _____
Dental X-ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV ☐ Yes ☐ No	Chicken Pox ☐ Yes ☐ No	Kidney Disease ☐ Yes ☐ No	Rheumatoid Arthritis ☐ Yes ☐ No
Alcoholism ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No	Liver Disease ☐ Yes ☐ No	Rheumatic Fever ☐ Yes ☐ No
Allergy Shots ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	Measles ☐ Yes ☐ No	Scarlet Fever ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Epilepsy ☐ Yes ☐ No	Miscarriage ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Anorexia ☐ Yes ☐ No	Fractures ☐ Yes ☐ No	Mononucleosis ☐ Yes ☐ No	Suicide Attempt ☐ Yes ☐ No
Appendicitis ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	MS ☐ Yes ☐ No	Thyroid Problem ☐ Yes ☐ No
Arthritis ☐ Yes ☐ No	Goiter ☐ Yes ☐ No	Mumps ☐ Yes ☐ No	Tonsillitis ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Gonorrhea ☐ Yes ☐ No	Osteoporosis ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No
Bleeding Disorder ☐ Yes ☐ No	Gout ☐ Yes ☐ No	Pacemaker ☐ Yes ☐ No	Tumors, Growths ☐ Yes ☐ No
Breast Lumps ☐ Yes ☐ No	Headaches ☐ Yes ☐ No	Parkinson's ☐ Yes ☐ No	Typhoid Fever ☐ Yes ☐ No
Bronchitis ☐ Yes ☐ No	Heart Disease ☐ Yes ☐ No	Pinched Nerve ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No
Bulimia ☐ Yes ☐ No	Hepatitis ☐ Yes ☐ No	Pneumonia ☐ Yes ☐ No	Vaginal Infections ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	Hernia ☐ Yes ☐ No	Polio ☐ Yes ☐ No	Venereal Disease ☐ Yes ☐ No
Cataracts ☐ Yes ☐ No	Herniated Disk ☐ Yes ☐ No	Prostate Problem ☐ Yes ☐ No	Whooping Cough ☐ Yes ☐ No
Chem. Dependancy ☐ Yes ☐ No	Herpes ☐ Yes ☐ No	Psychiatric Care ☐ Yes ☐ No	Other: _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Please list all Injuries/Surgeries you have had: Description Date

Falls _____ _____
Head Injuries _____ _____
Broken Bones _____ _____
Dislocations _____ _____
Surgeries _____ _____

Offers apply to new patients only (does not include personal injury or workman's compensation cases).
Medicare, Medicaid, Tricare recipients excluded by law.

3 Lifestyle

Infinity Wellness and Chiropractic

Exercise
- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

Work Activity
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

Habits
- ☐ Smoking
- ☐ Alcohol
- ☐ Coffee/Caffeine Drinks
- ☐ High Stress Level

Values

Please list your interests in order of importance from 1 to 7 (1= most important)

_____ Family _____ Financial _____ Social _____ Physical
_____ Mental _____ Spiritual _____ Work

4 Medications

1) _____
2) _____
3) _____

Pharmacy Name: _____

Pharmacy Phone: (____) _____

Allergies

1) _____
2) _____
3) _____
4) _____

How often do they occur?

_____

Vitamins/Supplements

1) _____
2) _____
3) _____
4) _____

☐ Daily ☐ Weekly ☐ Occasionally

5 Patient Information

Date _____

Patient Name (Last Name) _____

(First Name) _____ (Middle Initial) _____

Email _____

Address _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birth Date _____

Social Security/DL # _____

☐ Married ☐ Single ☐ Partnered for ____ Yrs.

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (____) _____

Spouse's Name _____

Birth Date _____

Social Security/DL # _____

Spouse's Employer _____

Who may we thank for referring you/event you attended?

_____

6 Insurance Information

Who is responsible for this account? _____

Relationship to patient _____

Insurance Co. _____

Patient ID # _____ Group # _____

Is this policy associated with an ☐ HSA ☐ FSA ☐ HRA ☐ Yes ☐ No

Is patient covered by additional/ Secondary insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birth Date _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Patient ID # _____ Group # _____

Assignment and Release

By signing below, I certify that the information on this form is accurate and up-to-date. I certify that I, and/or my dependent(s) have insurance coverage with the aforementioned company (ies) and assign directly to Infinity Wellness and Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that 1) I am financially responsible for all charges whether or not paid by insurance and 2) I am financially responsible for any legal fees incurred by Infinity Wellness and Chiropractic for collection efforts of delinquent balances on my and/or my dependent's(s') account(s). I authorize the use of my signature on all insurance submissions.

The above-named office may use my healthcare information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. The consent will end when my current treatment plan is completed or one year from the date below.

_____
(Signature of Patient, Parent, Guardian or Personal Representative)

_____
(Please print name of Patient, Parent, Guardian or Personal Representative)

_____ _____
(Date) (Relationship to Patient)

7 Phone Numbers

Cell Phone (____) _____ Home Phone (____) _____

Best time and place to reach you _____

In Case of Emergency, Contact

Name _____ Relationship _____

Home Phone (____) _____ Work Phone (____) _____

8 Family Information

Children's Name(s)	Sex	Dates(s) of Birth
_____	M F	_____
_____	M F	_____
_____	M F	_____
_____	M F	_____
_____	M F	_____

Offers apply to new patients only (does not include personal injury or workman's compensation cases).
Medicare, Medicaid, Tricare recipients excluded by law.

Terms of Acceptance

Infinity Wellness and Chiropractic

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic only has one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Chiropractic care like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke. Prior to receiving chiropractic care from Infinity Wellness and Chiropractic, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

It is important to note, we do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxation or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the chiropractor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

_____

(Signature) (Date)

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____ ,have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above practice 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 period: ____/____/____

_____

(Signature) (Date)

Infinity
Wellness and Chiropractic

Consent To Health Care Services/Release of Health Care Information

You, (the undersigned Patient, or undersigned person responsible for consenting on Patient's behalf) hereby request and consent to Patient health care services from Infinity Wellness and Chiropractic. The Patient health care services will be provided by licensed, treating chiropractors. Health care services will also be provided by non-chiropractic health care professionals employed, under contract, or otherwise retained by Infinity Wellness and Chiropractic. Medical, nursing, and other health care personnel who are in training may also participate in the Patient's care as part of their education.

_____ initial

Payment Guarantee

In consideration of the services provided by Infinity Wellness and Chiropractic, Provider to Patient, you agree to; I) guarantee payment of all charges incurred by Patient in connection with such services ("Patient Charges"); II) irrevocably assign and transfer to Infinity Wellness and Chiropractic, all right, title and interest to medical reimbursement benefits to which Patient is entitled for the purpose of payment of Patient Charges; and III) authorize payment of such benefits directly to Infinity Wellness and Chiropractic. You also agree to be fully responsible for the payment of any and all Patient Charges to the extent that these charges are not satisfied by the assigned benefits and the payment of any legal fees incurred by Infinity Wellness and Chiropractic for efforts to collect any delinquent balances of aforementioned unpaid Patient Charges.

If you have insurance, insurance companies will only pay what is covered in each individual's insurance policy. If your insurance policy does not cover services rendered from this office, then you are responsible for the non-covered services at the time they were rendered. If you have a Health Savings Account (HSA), Flex Spending Account (FSA) or a Health Reimbursement Arrangement (HRA), you must notify the practice so we may make appropriate accommodations for the plans. Infinity Wellness and Chiropractic does not directly bill to any HSA, FSA or HRA plans; however, depending on your plan arrangements, automatic withdrawals may occur when we submit to your primary insurance. Any refunds or reimbursements to HSA, FSA or HRA plans cannot exceed your "out of pocket" contribution towards any treatment. (Excludes introductory screening offer if applicable, all services will be discussed prior to being provided.)

_____ initial

Medicare

You certify that any information given by you as the Patient or Patient Representative in applying for payment under Title XVIII(18) of the Social Security Act is correct. You authorize any holder of medical or other information about Patient to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medical claim. You authorize payment or authorized benefits to Infinity Wellness and Chiropractic on Patient's behalf.

_____ initial

Consent to Release of Information

Infinity
Wellness and Chiropractic

Please Continue and Sign Consent To Release of Information

Here at Infinity Wellness and Chiropractic we respect your privacy, we do not sell or release your information to third parties. There will be cases along the course of your care where information will need to be released in certain circumstances. You authorize Infinity Wellness and Chiropractic to release to employer groups, government agencies (Medicare, Medicaid, Champus, State or Federal government etc.), insurance companies, or other third-party payers and their agents, and its collection representatives and attorneys, the following "Patient Information": medical history, diagnoses and procedures performed, course of treatment, plan of care, prognosis, supplies and/or such other information that may be requested for the purpose of determining eligibility and availability of Patient's benefits, obtaining authorization/payment for Patient's health care services, or billing and collection of amounts due to Infinity Wellness and Chiropractic for services rendered. In the case of Patient Information released for purposes of payment of Patient Charges, this authorization shall be valid only for the period of time necessary to process payment claims. You agree to pay any Patient Charges that are denied or are ineligible for medical reimbursement benefits as a result of your refusal or revocation of consent to disclose Patient Information.

You further authorize any individual health care professional, including treating physician(s), to provide Infinity Wellness and Chiropractic or its designee with Patient Information for quality assurance and, or risk management purposes. Finally, in the event that the Patient's employer, or an insurance company representing such employer, requests Patient Information relating to healthcare services provided for worker's compensation injuries, it is understood and agreed that Infinity Wellness and Chiropractic is required, under state law, to release copies of such information to such employer or insurance company without the authorization of Patient or Patient's representative. Again here at Infinity Wellness and Chiropractic we strive to provide you with the best care possible and in order to do that this consent is needed.

_____ initial

Responsibility For Personal Property

You accept sole responsibility for all Patient property, except for property expressly accepted by Infinity Wellness and Chiropractic for safekeeping under its sole care and custody.

No revisions or changes to this form, by you, will be accepted by Infinity Wellness and Chiropractic.

_____

(Signature of Patient or Responsible Party; parent, guardian or other representative) (Date)

_____

(Signature of Policyholder) (Relationship) (Date)

_____

(Signature of Witness to signing of consent form) (Date)

Patient Privacy Acknowledgement

Infinity Wellness and Chiropractic

For use and/or disclosure of Protected Health Information (PHI) to carry out Treatment, Payment and Healthcare Operations

I, _____, hereby state that by signing this Consent I acknowledge and agree as follows:
(Print Name)

1) The Practice's Privacy Notice has been provided to me prior to my signing this Consent. 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 carry out its health care operations. The Practice explained to me that the Privacy Notice would be 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 my 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 law.

3) The Practice's "Notice of Privacy Practices" is also provided in the reception area display table and on the Practice's web site at www.infinitywellnessandchiropractic.com. I may also request a copy from this office at any time 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.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

(Name of Individual - Printed)	(Date Signed)	(Signature of Individual)
(Signature of Legal Representative)	(Date Signed)	(Relationship)
(Witness - Office Personnel)		(Date Signed)