Today's Date: _____

INFINITY WELLNESS CENTER
Chiropractic & Acupuncture

Acupuncture Intake Form

Name:		**Email:**
Address:		
City, State, Zip:	**DOB:**	**Age:**
Home Phone:		**Cell Phone:**
Emergency Contact (Name & Phone):		
Referred by:		**Marital Status:**
Occupation:		
Have you ever had acupuncture before?		**With whom and results?**
Reason for today's visit:		
How long have you had this condition?		**Is it getting worse?**
Does it bother your: ☐ **Sleep** ☐ **Work** ☐ **Other (What?)**		
Is this your first time with this condition?		
What seems to make it better?		**What seems to make it worse?**
Other concurrent therapies?		***Have you taken corticosteroids in the past 30 days?***

Healthcare Providers ---please list those you work with.

Physicians: GP/Primary Care: _____ seeking one? □ Y □ N
OB-GYN: _____ seeking one? □ Y □ N
Specialist (describe): _____ seeking one? □ Y □ N
Chiropractor: _____ seeking one? □ Y □ N
Massage Therapist:_____ seeking one? □ Y □ N
Physical Therapist:_____ seeking one? □ Y □ N
Psychotherapist:_____ seeking one? □ Y □ N
Personal Trainer:_____ seeking one? □ Y □ N
Midwife:_____ seeking one? □ Y □ N
Other:_____
May I contact these providers to ensure coordination of your care? □ Y □ N
Previous experience with acupuncture? □ Y □ N
With whom and results_____

Acupuncture Consent

I hereby volunteer consent to receiving acupuncture and Oriental Medicine Treatment for my present and future health conditions. I understand the treatment will be administered by Infinity Wellness Center Chiropractic & Acupuncture.

Acupuncture and Oriental medicine treatments that may be administered:

Acupuncture: this is a safe treatment involving the insertion of tiny sterile (and disposable) needles through the skin, which can produce a mild and temporary discomfort (usually achiness or soreness. Other possible risks in acupuncture include dizziness and fainting. I will report to the doctor any dizziness or light headedness that occurs during and/or after an acupuncture treatment. Rare risks of acupuncture (these have an extremely low incidence, especially when acupuncture is administered properly) including fainting, nerve damage, organ puncture (pneumothorax) and infection.

I understand that no promise has been made regarding the outcome of treatment and that reasonable efforts will be made to give information to me so that I might make an educated decision regarding the duration and the appropriateness of continues care. I do not expect the doctor to be able to anticipate and explain all the risks and complications. I wish to rely on the doctor to exercise judgement during the course of the procedure, which he feels at the time, based upon the facts then known, and is in my best interests.

By signing below, I acknowledge that:

I have read or have read to me the information on this consent form. I understand the possible risks and complications involved. I have the opportunity to discuss this consent with the doctor. I understand I can request more information at any time if desired. I consent to receiving treatment that involves the above procedures. I understand that I have the rights to refuse or discontinue any treatment at any time. I understand that this refusal may affect the expected results.

Patient Name (Please Print)_____ **Date:**_____

Patient/Guardian Signature_____

AUTHORIZATION FOR CARE

I hereby authorize the doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

***Ownership of X-ray Films:** It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negative will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office.*

INITIAL IF READ ABOVE: _____

TERMS OF ACCEPTANCE

When accepting a new client who is seeking chiropractic, A.M.I.T, pulse, Class IV laser, dry needling, cupping, and/or acupuncture, it is essential for both the client and the doctor to be working towards the same objective. Chiropractic has only one goal to work toward the cause, not the effect. It is only when the client understands both the objective and the method that they will be able to attain it. This will prevent any confusion or disappointment.

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 to the spine. Health is a state of optimal physical, mental and social well being, not merely the absence of disease. Vertebral Subluxation is a misalignment of one or more of the joints in the body. This can cause pain or alteration of nerve function and interference of the transmission or nerve impulses, lessening the body's innate ability to maintain maximum health.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, 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 a health care provider who specializes in that area. 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 subluxation.

I have read and fully understand the above statement. Any questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

INITIAL IF READ ABOVE: _____

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of you records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- *Conduct, plan, and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly*
- *Obtain payment from third party payers.*
- *Conduct normal healthcare operations such as quality assessments and physician's certifications.*
- *You may request super bill, documentary of visits by email.*

I have read and understood your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict

PATIENT NAME (PLEASE PRINT):	RELATIONSHIP TO PATIENT (if minor):
SIGNATURE:	DATE:

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