INFINITY WELLNESS CENTER
Chiropractic & Acupuncture

PULSE Intake Form

Name:	**Email:**	
Address:		
City, State, Zip:	**Date of Birth:**	**Age:**
Home Phone:	**Cell Phone:**	
Emergency Contact (Name & Phone):	**Marital Status:**	
Referred by:	**Occupation:**	
☐ **Male** ☐ **Female**	**Height:** **Weight:**	
Have you ever had PULSE before?	**Date of last session:**	
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?**	
Are you under the care of a physician now? ☐ **Yes** ☐ **No** **If yes, for what?**		
Who is your physician?	**Physician's Phone?**	

Other concurrent therapies? _____

Surgeries:_____

Medications:_____

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Pulse System: Pulsed Magnetic Cellular Exerciser
Informed Consent for Demonstration, Session, or Purchase

I, _____, hereby request a Pulsed Magnetic Cellular Exercise session. I understand that the Pulse System creates a fully adjustable pulsed magnetic field. I understand that the information shared by the demonstrator are his/her personal opinions and are intended for educational purposes only.

Product Disclaimer
The Pulse System produces magnetic field energy, which passes freely through tissue for the purpose of cellular exercise to promote and support a sense of wellbeing. The FDA has not evaluated the Pulse System. It is not intended for the diagnosis, treatment or cure of any medical condition. The Pulse System is not a medical device and we cannot make any claims that we can affect medical conditions. The Pulse System is a service that is not covered by insurance and cannot be submitted for reimbursement.

We understand this general statement regarding pulsing magnetic fields to be accurate:
"*PEMF (pulsed electromagnetic field) devices do not treat a specific condition. Instead they optimize the body's natural self-healing and self-regulating function."*
- Dr. Magda Havas, Associate Professor of Environmental & Resource Studies at Trent University

Do not use if:
- ***You have an implanted electronic device including: pacemaker, defibrillator, cochlear hearing device, spinal stimulator, insulin pump, etc.***
- ***You are pregnant.***
- ***You are actively bleeding, hemorrhaging, or during heavy menstruation***.

Before beginning a PEMF Exercise Session we recommend the following:
Remove the following from your person: electronic or battery operated devices, cell phones, keys, wallets, cards with magnetic strips such as credit cards and hotel keys, all jewelry, and hearing aids.
If you are unsure whether pulsed magnetic cellular exercise is right for you, consult with your licensed health care provider(s).

During a PEMF Exercise Session
If you experience natural reactions that include but are not limited to nausea, headache, fatigue or any uncomfortable sensations we recommend you suspend the session and consult your doctor.

Beyond what is stated above, I, _____, understand that other risks associated with a pulsed magnetic exercise session are unforeseeable and that the demonstrator, the manufacturer, the marketer, employees, agents and affiliates cannot accept any liability for loss or damages incurred as the result of the Pulse System session. I reserve the right to use the knowledge I have gained in the care of my own body in any legal manner I may choose. I have read this form and voluntarily agree to the Pulse System session on my person assuming all liability for any and all results or consequences.

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

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 how my personal information is used and/ or disclosed.

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

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