MARIETTA HEALTH & WELLNESS CENTER

325 FOURTH STREET
MARIETTA, OHIO 45750

P :: 740 . 376 . 9944
E :: info@mymariettahealth.com

CONSENT TO TREAT A MINOR

I hereby authorize Dr. Jeffrey R. Dexter, DC, and/or his staff to examine and/or treat my daughter/son.

_____

Full Name of Child (please print)

_____

Address

_____ _____ _____

City *State* *Zip Code*

_____

Phone number

SIGNED

_____ _____ _____

Name of parent or legal guardian (please print) *Signature of parent or legal guardian* *Date*

WITNESS

_____ _____ _____

Name (please print) *Signature* *Date*

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INFORMED CONSENT

DOCTOR-PATIENT RELATIONSHOP IN CHIROPRACTIC

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes,_physical and spinal conditions. It is important to understand what to expect from chiropractic health care services.

ANALYSIS

A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS

Although doctors of chiropractic are experts in chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or health care, if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from; latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures; the doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

RESULTS

The purpose of chiropractic services is to promote natural health through the reduction of the VSS or VSc. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometimes the response is phenomenal. In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic, in turn, we must admit that conditions which do not respond to chiropractic care may come under the control or be helped tluough medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems, both have made great strides in alleviating pain and controlling disease.

TO THE PATIENT

Please discuss any questions or problems with the doctor before signing this statement of policy.

I have read, and understand the foregoing.

_____	_____	_____
Patient name (please print)	*Patient signature*	*Date*

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NOTICE OF PRIVACY PRACTICES

REQUESTS TO INSPECT PERSONAL AND COPY YOUR HEALTH INFORMATION

You have the right to inspect and/or copy your health information for seven years from the date the record was created. We require your request to inspect and/or copy your health information be in writing.

YOUR RIGHT TO COMPLAIN

You may complain to us if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be addressed to:

Jeffrey R. Dexter, DC | Marietta Health & Wellness Center | 325 Fourth Street | Marietta, OH 45750

OUR DUTIES

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information.

We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement we will notify you in writing when you come in for treatment or by mail. If we make a change in our privacy terms the change will apply to all of your health information.

TO CONTACT US

If you would like further information about our privacy policies and practices please contact:

Jeffrey R. Dexter, DC | Marietta Health & Wellness Center | 325 Fourth Street | Marietta, OH 45750 | 740-376-9944

TO THE PATIENT

This notice is in effect as of March 13, 2007. This notice will expire seven years after the date upon which the record was created. By signing below, I acknowledge that I have received a copy of this notice.

_____	_____	_____
Patient name (please print)	*Patient signature*	*Date*

_____

Signature of parent or legal guardian

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

YOUR RIGHT TO LIMIT USES OR DISCLOSURES

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing.

YOUR RIGHT TO REVOKE YOUR AUTHORIZATION

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we received your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decide to contest any of your claims.

APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

Your chiropractor and members of the staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not home, a message will be left on your answering machine or with the person answering the phone. By signing this form, you are giving us authorization to contact you with these reminders and information. You have the right to refuse to give this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

YOUR RIGHTS

You have certain rights under the federal privacy standards. These include:

- The right to receive confidential communications concerning your medical treatment.
- The right to see and copy your protected health information
- The right to receive confidential communications about your medical condition and treatment
- The right to amend or make corrections to your personal health information
- The right to receive an accounting disclosure of your personal health information.
- The right to receive a paper copy of our privacy notice

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PATIENT REGISTRATION

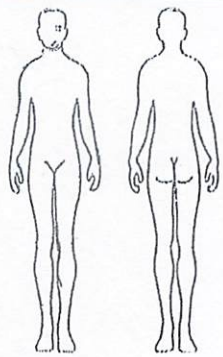
PATIENT CONDITION

Reason for Visit _____

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

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

FOR WOMEN ONLY:

Last Menstrual Cycle	Age period began	Problems with cycles	
Birth Control	Date of last Pap	# of live births	# of pregnancies
Problems with pregnancies	Date of last Mammogram		Age at Menopause

PLEASE LIST ALL SURGERIES AND/OR HOSPITALIZATIONS

Surgery	Surgeon	Year	Hospitalizations	Year

PLEASE ALL MEDICATIONS YOU ARE CURRENTLY TAKING

Name of medication	Strength	How many / How often	Purpose

Please list any medication allergies you may have: _____

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PATIENT REGISTRATION

ARE YOU EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS? (CHECK ALL THAT APPLY)

☐ Fatigue	☐ Weight Changes	☐ Blurred Vision	☐ Eye Drainage	☐ Earache
☐ Nosebleeds	☐ Nasal Congestion	☐ Chest Pain	☐ Dizziness	☐ Sore Throat
☐ Swelling	☐ Cough	☐ Constipation	☐ Diarrhea	☐ Nausea
☐ Blood In Stool	☐ Urinary Frequency	☐ Urinary Burning	☐ Joint Pain	☐ Muscle Pain
☐ Rashes	☐ Skin Growths	☐ Passing Out	☐ Headaches	☐ Swollen Glands
☐ Hot Flashes	☐ Seasonal Allergies	☐ Anxiety	☐ Depression	☐ Difficulty Sleeping
☐ Ringing in Ears	☐ Hoarseness	☐ Vomiting	☐ Back Pain	☐ Heat/Cold Intolerance

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING? IF SO, WHEN?

(CHECK ALL THAT APPLY)

☐ Hypertension		☐ Gallbladder Disease		☐ Skin Disease	
☐ Heart Attack		☐ Liver Disease		☐ Mental Illness	
☐ Stroke		☐ Anemia		☐ Migraines	
☐ Heart Disease		☐ Allergies		☐ ADHD	
☐ High Cholesterol		☐ Kidney Disease		☐ Tuberculosis	
☐ Asthma		☐ Seizures		☐ Mononucleosis	
☐ COPD		☐ Arthritis		☐ Chicken Pox	
☐ Diabetes		☐ Osteoporosis		☐ Hepatitis	
☐ Thyroid Disorder		☐ Serious Injury		☐ Genital Herpes	
☐ Cancer		☐ Ear Problem		☐ Other	
☐ GERD		☐ Eye Problem			

FAMILY HISTORY: HAS ANY FAMILY MEMBER BEEN TREATED FOR ANY OF THE FOLLOWING?

Relationship to you? Mother/Father side?

☐ No knowledge of family history	☐ Liver Disease	☐ Glaucoma
☐ Heart Disease	☐ Peptic Ulcer Disease	☐ Skin Disease
☐ Hypertension	☐ Kidney Disease	☐ Allergies
☐ High Cholesterol	☐ Alzheimer's	☐ Arthritis
☐ Asthma	☐ Stroke	☐ Osteoporosis
☐ Tuberculosis	☐ Migraines	☐ Gout
☐ Gallbladder	☐ Seizure Disorder	☐ Anemia
☐ Cancer Type?	☐ Mental Illness Type?	☐ Diabetes

SOCIAL HISTORY

Are you currently employed? Occupation:

Do you attend school? Grade: School Name:

Do you now or have you ever:	Smoked?	☐ Yes	☐ No	Packs/day:	# of years
	Drink Alcohol?	☐ Daily	☐ Weekly	☐ Rarely	☐ Never
	Use Caffeine?	☐ Daily	☐ Weekly	☐ Rarely	☐ Never
	Are you exposed to tobacco smoke?	☐ Yes	☐ No		
	Use illegal drugs?	☐ Yes	☐ No		
	Exercise?	☐ Yes	☐ No	Days/week:	

Are your immunizations current? If not, please explain

Have you had a Tetanus shot in the last 10 years? If so, when?

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PATIENT REGISTRATION

Today's date: _____ Primary Care Physician: _____

PATIENT INFORMATION

Patient's last name: _____ First: _____ Middle: _____ ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. Marital Status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ☐ Yes ☐ No If not, what is your legal name? _____ (Former Name): _____ Birth date: / / Age: _____ Sex: ☐ M ☐ F

Street Address: _____ Social Security No.: _____ Home phone No.: ( )

P.O. Box: _____ City: _____ State: _____ ZIP Code: _____

Occupation: _____ Employer: _____ Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ☐ Dr. ☐ Insurance Plan ☐ Hospital
☐ Family ☐ Friend ☐ Close to home/work ☐ Yellow Pages ☐ Other

Patient's email address _____

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: _____ Birth date: _____ Address (if different) _____ Home phone no.: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation: _____ Employer: _____ Employer Address: _____ Employer phone no: (

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance: ☐ Anthem ☐ Med Mutual ☐ MSBCBS ☐ Aetna ☐ Medicare

☐ Medicaid (Please provide coupon) ☐ Other

Subscriber's name: _____ Subscriber's S.S. No.: _____ Birth date: / / Group no: _____ Policy No.: _____ Co-payment: $_____

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance (if applicable): _____ Subscriber's name: _____ Group No.: _____ Policy No.: _____

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Name of local relative or friend (not living at same address): _____ Relationship to patient: _____ Home phone no.: ( ) _____ Work phone no." ( ) _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize MHWC or insurance company to release any information required to process my claims.

Patient/Guardian signature _____ Date: _____