Welcome to Lifeline Chiropractic

Name:_____ SS#_____-_____-_____
Nickname:_____ Today's Date:_____-_____-_____
Address:_____ City:_____ State:___ Zip:_____
Sex: □ Male □ Female Date of Birth:_____(MM/DD/YYYY) Age:_____
Cell Phone #:_____ Home Phone #:_____
Do you text? □ Yes □ No
Email:_____ Occupation:_____
Whom may we thank for referring you to us?_____

Do you have insurance? □ Yes □ No
Insurance Company Name:_____
Name of Insured:_____ Insured Date of Birth:_____
Relationship to Insured:_____ ID #_____

PLEASE PRESENT A COPY OF YOUR INSURANCE CARD

What brings you to the office?_____
When did you first notice this problem?_____
What activities are difficult to perform? □ Sitting □ Standing □Walking □ Bending □ Lying Down □ Sleeping
Type of Pain: □ Sharp □ Throbbing □ Shooting □ Burning □ Tingling □ Cramping □ Stiffness □Swelling

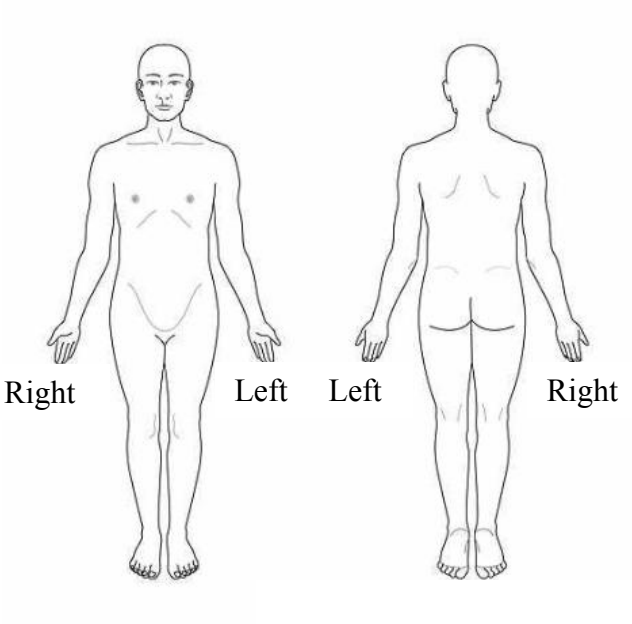
What are you doing for this problem? _____
What medication are you currently taking? _____
Have you been to a Chiropractor before? □ Yes □No Date of last visit:_____

Check the conditions/symptoms below that apply to you:

□ Headaches
□ Neck Pain
□ Mid-Back Pain
□ Low-Back Pain
□ Sciatic Pain
□ Leg or Hip Pain
□ Arm Pain
□ Shoulder Pain
□ Carpal Tunnel
□ Sleeping Issues
□ Ringing in the ears
□ Loss of Balance
□ High Blood Pressure
□ Weight Gain/Loss
□ Low Energy/Fatigue
□ Asthma
□ Allergies
□ Dizziness
□ Vertigo
□ Depression
□ Cancer
□ Digestive Problems
□ Numbness
□ Heart Problems
□ Lung Problems
□ Joint Problems
□ Reproductive Problems
□ Other:_____
_____
_____

Using the symbols below, mark on the pictures where you feel pain:

Numbness	NNN
Dull Ache	AAA
Burning	BBB
Sharp/Stabbing	SSS
Pins, Needles	PPP
Other:_____	XXX
_____	



Terms of Service

When a person seeks chiropractic health care and we accept someone for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal, to detect and correct/reduce the vertebral subluxation. It is important that each person 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 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 vertebra 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 wisdom/ability to express its maximum health potential.

Through your exam and with each visit we will identify where the levels are where your spine is subluxated. Those will be the areas where you will be adjusted in order to increase your body's ability to function and heal, increasing your overall health.

I,(Name)_____(Signature)_____undertake any care with the understanding of and agreement with, the above explanation._____(Date)

Consent to evaluate and adjust a minor and/or child: I,_____(Print name) being the parent or legal guardian of _____(Print name) give permission for my child to receive any care. (Signature)_____

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

In the course of your care as a patient we may use or disclose personal and health related information about you in the following ways:
*Your personal health information, including of your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment, or treatment.
*Your health care records as well as your billing records may be disclosed to another party, such as insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
*Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, missed appointments and related appointment issues, workshops, listing your name on our welcome or referral boards, sending thank you, birthday, or welcome cards, publishing your success stories, taking pictures, and information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have a right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:
*If we provide health care services to you based on the orders of another health care provider.
*If we provide health care services to you in an emergency.
*If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
*If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
*If we are ordered by the courts or another agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home, or if you would like the information in a different form please advise us in writing as to your preferences. You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy, or amend your health information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice we will notify you in writing as soon as possible following changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules. If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you can and should direct them to Dr. Carol.

This notice is effective June 1, 2011. This notice, and any alterations or amendments made hereto will expire seven years after date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____ _____ _____

Name (Printed please) Signature Date

If you are a minor, or if you are being represented by another party

_____ _____ _____

Representative Name (Print) Signature Date

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, and if necessary, diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible:_____) by the chiropractor. I further understand that such chiropractic services may be performed by the chiropractor, Dr. Carol Iaizzi and/or other licensed chiropractors who may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Carol and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all health care, the practice of chiropractic carries some risks to treatment, including, but not limited to, fractures, disc injuries, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. Further, I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels are in my best interests, at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my doctor. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the patient or legal guardian:

Print Patient's Name Signature of Patient Date

_____ _____ _____