ZOVA

1

WELCOME TO OUR PRACTICE.

Date_____ Pt #_____

Patient_____
First Middle Last

I prefer to be called_____

Address_____

_____
City State Zip

Cell #_____ Cell Provider_____

Home #_____ Work #_____

Email_____

Reminders: ❑ Text or ❑ Email? ___hr or ___day before?

Gender: ❑ M ❑ F Age____ Birthdate_____

Patient's SS#_____

❑ Single ❑ Married ❑ Other

❑ Right-handed ❑ Left-handed ❑ Ambidextrous

Preferred Language_____

The following two questions are requested as part of CMS EHR Incentive Program to identify gaps in care.
Race: ❑ American Indian or Alaska Native, ❑ Asian, ❑ Black or African American, ❑ Native Hawaiian or Other Pacific Islander, ❑ White, ❑ Other.
Ethnicity: ❑ Hispanic or Latino, ❑ Not Hispanic or Latino.

❑ Employed ❑ Full-time student ❑ Part-time student

Occupation_____

Employer or School_____

Employer or School Address_____

_____

Whom may we thank for referring you?_____

_____

2

YOUR MEDICAL DOCTOR

Doctor_____MD/DO
First Last

Location_____

We like to coordinate care with your medical doctor.
May we send reports to this doctor? ❑ Yes ❑ No

3

Spouse's Name_____

Spouse's Birthdate_____ SS#_____

Spouse's Occupation_____

Spouse's Employer_____

Spouse's Cell #_____ Work #_____

4

IN CASE OF EMERGENCY, CONTACT
❑ Spouse or ❑ Other Contact:

Name_____ Relationship_____

Cell #_____ Work #_____

5

CONSENT & POLICIES

1. I understand and agree to allow the clinic to use my Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. **The information authorized for release may include records which may indicate the presence of a communicable or noncommunicable disease**.

2. I hereby authorize the clinic, Dr. Michael K. Van Antwerp, and his assigns to examine, test, x-ray, and administer treatment to me as they deem necessary.

3. I understand that all first visit charges are payable when services are rendered. I will be taking care of today's charges by: ❑ Cash ❑ Check ❑ Credit Card ❑ Voucher ❑ Auto insurance

4. ❑ I choose to decline receipt of my CMS EHR Incentive Program clinical summary after every visit. (Checking this box means you do not want a list of diagnosis codes or often just a blank summary, etc after every visit. This is separate from requesting your medical records which you can do at any time).

_____ _____
Patient Signature (or Parent/Guardian Signature) Date

6

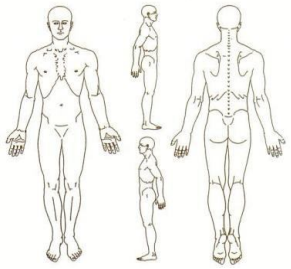
CONSENT TO TREATMENT OF A MINOR CHILD

I hereby authorize the clinic including Dr. Michael K. Van Antwerp and his assigns to examine, test, x-ray, and administer treatment as they deem necessary to my child _____. This shall extend to subsequent office visits with or without my presence. This is to serve as long-term authorization and is to apply to all occasions of service until it is revoked in writing.

_____ _____
Parent or Guardian Signature Date

_____ _____
Witness Signature Date

►CHIEF COMPLAINTS and ►HISTORY OF PRESENT ILLNESS:
We address a wide range of complaints. Please, mark the major area(s) that you are seeking care for today:



❑ Headache ❑ Jaw ❑ Neck ❑ Upper Back ❑ Mid Back ❑ Low Back ❑ Pelvis ❑ Hip ❑ Thigh
❑ Knee ❑ Lower Leg ❑ Ankle ❑ Foot ❑ Toe B 2 3 4 5 ❑ Shoulder ❑ Upper Arm ❑ Elbow
❑Forearm ❑ Wrist ❑ Hand ❑ Finger T 2 3 4 5 ❑ Chest ❑ Ribs ❑ Tailbone ❑ Groin ❑_____

Other problems:
❑ Digestion ❑Breathing ❑ Sleeping ❑ Concentration ❑ Lack of energy ❑ Sick a lot ❑ Stress

Write in the on the additional problem areas in order of importance, indicate R (right) or L (left), and mark additional information about them. Intensity is 0=no intensity and 10=worst intensity.

1. _____	**Intensity at its Best:** 0 1 2 3 4 5 6 7 8 9 10	**Intensity at its Worst:** 0 1 2 3 4 5 6 7 8 9 10
Percentage of day occurs: ❑ 75-100 ❑ 50-75 ❑ 25-50 ❑ 0-25	Symptoms: ❑ Pain ❑ Stiffness ❑ Numbness❑ Tingling ❑ Swelling ❑ Weakness	
	Pain is: ❑ Pulling ❑ Aching ❑ Squeezing ❑ Stabbing ❑ Itching ❑ Cutting ❑ Burning	
Radiates: ❑ R ❑ L ❑ None	Date started: _____/_____/_____	
How did problem occur?		
Notes:		

2._____	**Intensity at its Best:** 0 1 2 3 4 5 6 7 8 9 10	**Intensity at its Worst:** 0 1 2 3 4 5 6 7 8 9 10
Percentage of day occurs: ❑ 75-100 ❑ 50-75 ❑ 25-50 ❑ 0-25	Symptoms: ❑ Pain ❑ Stiffness ❑ Numbness❑ Tingling ❑ Swelling ❑ Weakness	
	Pain is: ❑ Pulling ❑ Aching ❑ Squeezing ❑ Stabbing ❑ Itching ❑ Cutting ❑ Burning	
Radiates: ❑ R ❑ L ❑ None	Date started: _____/_____/_____	
How did problem occur?		
Notes:		

3. _____	**Intensity at its Best:** 0 1 2 3 4 5 6 7 8 9 10	**Intensity at its Worst:** 0 1 2 3 4 5 6 7 8 9 10
Percentage of day occurs: ❑ 75-100 ❑ 50-75 ❑ 25-50 ❑ 0-25	Symptoms: ❑ Pain ❑ Stiffness ❑ Numbness❑ Tingling ❑ Swelling ❑ Weakness	
	Pain is: ❑ Pulling ❑ Aching ❑ Squeezing ❑ Stabbing ❑ Itching ❑ Cutting ❑ Burning	
Radiates: ❑ R ❑ L ❑ None	Date started: _____/_____/_____	
How did problem occur?		
Notes:		

- How much have your symptoms interfered with your usual daily activities?
  ❑ Not at all ❑ A little bit ❑ Moderately ❑ Quite a bit ❑ Extremely
- How is your condition changing since beginning care at this facility? ❑ **N/A - This is the initial visit**
  ❑ Much better ❑ Better ❑ A little better ❑ No change ❑ A little worse ❑ Worse ❑ Much worse
- In general, would you say your overall health right now is ❑ Excellent ❑ Very good ❑ Good ❑ Fair ❑ Poor
- Previous chiropractic care? ❑ No ❑ Yes Were extremities, muscles, and exercises addressed? ❑ No ❑ Yes
  What did you like?_____ What did you not like?_____

The information on this page is accurate to the best of my knowledge. ***Patient Signature:*** **X**_____

Pt Name_____ Pt #_____ Date_____ Reviewed_____

PATIENT MOTOR VEHICLE COLLISION HISTORY FORM

Name _____ **Date** _____

Date of Loss (Collision Date): _____ **Claim Number:** _____

Describe Accident:

_____

_____

_____

Specifics of Accident (Mark each that applies to the accident):
Job or Work Related injury ❑ Yes ❑ No

You were the ❑ Driver ❑ Passenger
Sitting ❑ Front seat ❑ Back seat

Impending collision ❑ Braced ❑ Not braced
Head did ❑ Strike Object ❑ Not strike Object
Did you experience ❑ Shock
❑ Flash of light seen upon impact
❑ Objects flying around vehicle

Immediately Following the Accident:

❑ Police came to scene and made report
❑ Ambulance/paramedics called
❑ Treated at scene
❑ Transported to hospital by ambulance
❑ Went to hospital or urgent care on your own
❑ Diagnostics performed at hospital or urgent care
❑ Medication prescribed
❑ Treatment at hospital or urgent care
❑ Follow-up recommended by healthcare providers

Time Loss

❑ NO time loss from work due to injury. I am currently working with No limitations.
❑ NO time loss form work due to injury BUT I do have limitations*.
❑ I have experienced time loss from work due to injury. Indicate number of days, weeks, etc
❑ N/A

*Describe limitations and what activities have been negatively affected:

_____

_____

Mechanism of Injury

Were you surprised by the impact? ❑ Yes ❑ No

In relation to the back of your head, was your headrest set: ❑ Low ❑ Middle ❑ High ❑ None

Where was your head facing at the time of impact? ❑ Left ❑ Forward ❑ Right ❑ Unknown

Were you leaning forward at the time of impact? ❑ Yes ❑ No

Were you wearing a seatbelt? ❑ Yes ❑ No

Did you have bruises or cuts from the seatbelt? ❑ Yes ❑ No

Did airbags deploy? ❑ Yes ❑ No

Did you have burns, scrapes, cuts or bruises from the airbag? ❑ Yes ❑ No

Were you rendered unconscious as a result of the accident? ❑ Yes ❑ No

Did you feel pain immediately after the accident? ❑ Yes ❑ No

Year and type of vehicle were you in? _____

Size of your vehicle? ❑ Small ❑ Mid ❑ Large ❑ Unknown

Year and type of other vehicle involved in the accident? _____

Size of other vehicle? ❑ Small ❑ Mid ❑ Large ❑ Unknown

What was the approximate speed of your vehicle when the accident occurred? _____

What was the approximate speed of the other vehicle when the accident occurred? _____

The information on this page is accurate to the best of my knowledge. ***Patient Signature:*** **X**_____

Pt Name_____ Pt #_____ Date_____ Reviewed_____

Pain Disability Questionnaire (PDQ)

Instructions: These questions ask your view about how your pain now affects how you function in everyday activities. Please answer every question and mark the ONE number on EACH scale that best describes how you feel.

1. Does your pain interfere with your normal work inside and outside the home?
Work normally — Unable to work at all
0 --------- 1 --------- 2 --------- 3 --------- 4 --------- 5 --------- 6 --------- 7 --------- 8 --------- 9 -------- 10

2. Does your pain interfere with personal care (such as washing, dressing, etc.)?
Take care of myself completely — Need help with all my personal care
0 --------- 1 --------- 2 --------- 3 --------- 4 --------- 5 --------- 6 --------- 7 --------- 8 --------- 9 -------- 10

3. Does your pain interfere with your traveling?
Travel anywhere I like — Only travel to see doctors
0 --------- 1 --------- 2 --------- 3 --------- 4 --------- 5 --------- 6 --------- 7 --------- 8 --------- 9 -------- 10

4. Does your pain affect your ability to sit or stand?
No problems — Cannot sit/stand at all
0 --------- 1 --------- 2 --------- 3 --------- 4 --------- 5 --------- 6 --------- 7 --------- 8 --------- 9 -------- 10

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?
No problems — Cannot do at all
0 --------- 1 --------- 2 --------- 3 --------- 4 --------- 5 --------- 6 --------- 7 --------- 8 --------- 9 -------- 10

6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?
No problems — Cannot do at all
0 --------- 1 --------- 2 --------- 3 --------- 4 --------- 5 --------- 6 --------- 7 --------- 8 --------- 9 -------- 10

7. Does your pain affect your ability to walk or run?
No problems — Cannot walk/run at all
0 --------- 1 --------- 2 --------- 3 --------- 4 --------- 5 --------- 6 --------- 7 --------- 8 --------- 9 -------- 10

8. Has your income declined since your pain began?
No decline — Lost all income
0 --------- 1 --------- 2 --------- 3 --------- 4 --------- 5 --------- 6 --------- 7 --------- 8 --------- 9 -------- 10

9. Do you have to take pain medication every day to control your pain?
No medication needed — On pain medication throughout the day
0 --------- 1 --------- 2 --------- 3 --------- 4 --------- 5 --------- 6 --------- 7 --------- 8 --------- 9 -------- 10

10. Does your pain force you to see doctors much more often than before your pain began?
Never see doctors — See doctors regularly
0 --------- 1 --------- 2 --------- 3 --------- 4 --------- 5 --------- 6 --------- 7 --------- 8 --------- 9 -------- 10

11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?
No problem — Never see them
0 --------- 1 --------- 2 --------- 3 --------- 4 --------- 5 --------- 6 --------- 7 --------- 8 --------- 9 -------- 10

12. Does your pain interfere with recreational activities and hobbies that are important to you?
No interference — Total interference
0 --------- 1 --------- 2 --------- 3 --------- 4 --------- 5 --------- 6 --------- 7 --------- 8 --------- 9 -------- 10

13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?
Never need help — Need help all the time
0 --------- 1 --------- 2 --------- 3 --------- 4 --------- 5 --------- 6 --------- 7 --------- 8 --------- 9 -------- 10

14. Do you now feel more depressed, tense, or anxious than before your pain began?
No depression/tension — Severe depression/tension
0 --------- 1 --------- 2 --------- 3 --------- 4 --------- 5 --------- 6 --------- 7 --------- 8 --------- 9 -------- 10

15. Are there emotional problems caused by your pain that interfere with your family, social and or work activities?
No problems — Severe problems
0 --------- 1 --------- 2 --------- 3 --------- 4 --------- 5 --------- 6 --------- 7 --------- 8 --------- 9 -------- 10

From: Anagnostis C et al: The Pain Disability Questionnaire: A New Psychometrically Sound Measure for Chronic Musculoskeletal Disorders. Spine 2004; 29 (20): 2290-2302.

Pt Name_____ Pt #_____ Date_____ Reviewed_____

►**REVIEW OF SYSTEMS**: Mark any of the following you have for each category or mark "N" for none in that section.

Constitutional: ❑ N
❑ Unexpected weight loss
❑ Fever
❑ Chills
❑ Night sweats
❑ Fatigue
❑ Loss of appetite
❑ Loss of sleep
❑ Night pain that wakes you

Eyes: ❑ N
❑ Blurry/Double vision
❑ Corrective lenses
❑ Vision loss

Ear/Nose/Throat: ❑ N
❑ Hearing loss
❑ Ringing in ears
❑ Sinus problems
❑ Tooth cavities
❑ Hoarseness
❑ Trouble swallowing

Respiratory: ❑ N
❑ Chronic cough
❑ Shortness of breath
❑ Wheezing

Cardiovascular: ❑ N
❑ Chest pains
❑ Palpitations
❑ Edema
❑ Cold extremities
❑ Fainting or near-fainting

Gastrointestinal: ❑ N
❑ Nausea
❑ Vomiting
❑ Diarrhea
❑ Constipation
❑ Heartburn/indigestion
❑ Gas
❑ Bloating
❑ Ulcers
❑ Blood in stool
❑ Abdominal pain
❑ Loss of bowel control

Genitourinary: ❑ N
❑ Painful urination
❑ Blood in urine
❑ Kidney problems
❑ Prostate problems
❑ Sexual dysfunction
❑ Urinary tract infections
❑ Menstrual irregularity
❑ Menstrual cramps
❑ Loss of bladder control

Musculoskeletal:
*See chief complaints
❑ Joint degeneration
❑ Difficulty walking
❑ Weakness

Integumentary: ❑ N
❑ Bruises/scrapes/cuts
❑ Rash
❑ Sores
❑ Clammy, moist skin
❑ Nail/hair changes
❑ Breast pain/lumps

Neurological: ❑ N
❑ Numbness
❑ Tingling
❑ Groin/crotch numbness
❑ Migraines
❑ Dizziness
❑ Seizures
❑ Tremors

Psychiatric: ❑ N
❑ Depression
❑ Anxiety
❑ Sleep disorder
❑ Forgetfulness
❑ Confusion
❑ Drug problem
❑ Alcohol problem

Endocrine: ❑ N
❑ Frequent thirst
❑ Frequent urination
❑ Heat/cold intolerance
❑ Goiter

Hematologic/Lymphatic: ❑ N
❑ Easy bruising/bleeding
❑ Blood clots
❑ Swollen lymph nodes

Allergic/Immunologic: ❑ N
*See allergies list
❑ Hives
❑ Anaphylactic reactions
❑ Sick frequently

FEMALES
Date of Last Period_____
Are you pregnant? ❑ Yes ❑ No

►**MEDICAL HISTORY**

CONDITIONS: Mark any of the following you have had or if do not have any of the conditions listed below mark ❑ None.

❑ Aneurysm
❑ Ankylosing spondylitis
❑ Anticoagulant meds
❑ Asthma/COPD
❑ Bone/Joint infection
❑ Cancer, type_____
❑ Chiari, type_____
❑ Corticosteroid meds
❑ Diabetes, type_____
❑ Ehlers-Danlos syn.___
❑ Epilepsy
❑ Gout
❑ Heart attack, year_____
❑ Heart failure
❑ Hemophilia
❑ Hepatitis, type_____
❑ High/Low blood pressure
❑ HIV/AIDS
❑ Immunosuppressive meds
❑ Injection drug use
❑ Joint laxity/instability
❑ Kidney failure
❑ Liver disease
❑ Low/High thyroid
❑ Marfan syndrome
❑ Multiple sclerosis
❑ Osteoporosis
❑ Pacemaker
❑ Psoriasis
❑ Recent infection
❑ Rheumatoid arthritis
❑ Sjogren syndrome
❑ Sleep apnea
❑ Stroke
❑ Tuberculosis
❑ Vertebrobasilar insuff.

Do you have ALLERGIES to any medications/drugs? ❑ Yes ❑ No. If yes, then list:

Mark any other known allergies: ❑ Adhesive tape ❑ Latex ❑ Iodine ❑ Contrast dye ❑ Seasonal ❑ Food ❑ Animal _____

Do you take MEDICATIONS? ❑ Yes ❑ No. Any SUPPLEMENTS? ❑ Yes ❑ No. If yes to either, list with dosage amount:

List any INJURIES/OPERATIONS you have had with a description and the year, or if haven't had any mark ❑ None.

❑ Auto Accidents_____ ❑ Broken Bones_____ ❑ Sprains/Strains_____
❑ Falls_____ ❑ Dislocations_____ ❑ Surgeries_____
❑ Head Injuries_____ ❑ Implants/Replacements_____ _____

►**FAMILY HISTORY**: Mark if any direct relatives have had the following, or if they haven't mark ❑ None. ❑ Same condition as you____ ❑ High blood pressure____ ❑ Diabetes_____ ❑ Rheumatoid arthritis____ ❑ Premature death____

►**SOCIAL HISTORY**

● Do you smoke or chew tobacco? ❑ Daily ❑ Occasionally ❑ Previously ❑ Never. If so, how much?_____
● Alcohol use? ❑ None ❑ Social ❑ Daily ❑ Frequently
● Work Habits: ❑ Sitting ❑ Standing ❑ Driving ❑ Bending ❑ Lifting
● Exercise: ❑ ___days/week ❑ Occasionally ❑ None. ● What activities or hobbies?_____

The information on this page is accurate to the best of my knowledge. ***Patient Signature:*** **X**_____

Pt Name_____ Pt #_____ Date_____ Reviewed_____

RELEASE AND ASSIGNMENT

The following agreements are necessary because insurance is an arrangement between you and the insurance company. The doctor and the clinic are not part of this arrangement, and thus need your release, assignment, and authorization.

1. I _____ authorize the request, release, and disclosure of any medical, health care, or other information necessary to process my insurance claims, to secure the payment of benefits, and to manage my care including communication with insurance companies, claims adjusters, case nurses, claims reviewers, employers, hospitals, clinics, healthcare providers, and attorneys. I understand that this might include multiple occurrences. This is to serve as a long-term authorization card. **The information authorized for release may include records which may indicate the presence of a communicable or noncommunicable disease**. This language is included as required by 63 O.S. § 1-502.2.

2. I directly assign my rights and benefits under my policy and authorize payment of all benefits directly to Dr. Michael K. Van Antwerp (hereinafter, "doctor") and ZOVA (hereinafter, "clinic"). This payment will not exceed my indebtedness to the above-mentioned doctor and clinic, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. I understand that I am ultimately responsible for the charges. This authorization is to apply to all occasions of service until it is revoked in writing.

3. If my current policy prohibits direct payment to doctor and clinic then I hereby instruct and direct the insurance company to make check to me as a patient and to mail it to me as follows: ZOVA, 2433 N. Aspen Ave., Broken Arrow, OK 74012

4. I do hereby designate Dr. Michael K. Van Antwerp and ZOVA to the full extent permissible under the Employee Retirement Income Security Act of 1974 ("ERISA") and as provided in 29 CFR 2560-503-1(b)4 to otherwise act on my behalf as my agent to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or other health care expense(s) incurred as a result of the goods and/or services I receive from the above-named doctor and clinic. These rights include the right to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records, and to claim on my behalf such medical or other health care service benefits, insurance or health care benefit plan reimbursement and to pursue any other applicable remedies, all in connection with medical or other health care expense(s) as the result of the goods and/or services I received from my doctor and clinic.

5. I agree that a photocopy of this agreement shall be effective and valid as the original.

_____	_____	_____
Patient Printed Name	Patient Signature	Date
_____	_____	_____
Parent or Guardian Printed Name	Parent or Guardian Signature	Date

SCHEDULING POLICY

Due to the nature of our clinic's one-on-one treatment, any last-minute cancellations or missed appointments can prevent another patient from getting much needed treatment. We understand that certain emergencies do come up, but in order to be respectful of the health needs of other patients, we need enough notice to fill your appointment with another patient. We also understand that in a healthcare clinic sometimes the schedule runs behind although we try to prevent it. To help this, any late arrivals will be seen if the provider does not have another patient waiting, otherwise the patient might have shortened treatment time or have to be completely rescheduled. To better utilize available appointments for all patients in need of care, we have the following policy:

If an appointment is cancelled or rescheduled within 24 hours of the appointment time, the fee is 50% of the scheduled treatment. If the appointment is completely missed (no-show), the fee is 100% of the scheduled treatment. Cancellations and rescheduled appointments need to be made directly to a staff member, not via texts, emails, or voicemail. As a benefit, we do send appointment reminders via text or email, but failure to receive one is not a reason for missed appointments. Insurance and other third party forms of payment do not pay for cancelled, rescheduled or missed fees. We do require a credit card on file in case these situations occur. Thank you for your commitment to our reserved time together.

_____	_____	_____
Patient Printed Name	Patient Signature	Date
_____	_____	_____
Parent or Guardian Printed Name	Parent or Guardian Signature	Date

INFORMED CONSENT

Dear Patient:

Healthcare providers need to obtain your informed consent prior to examination and treatment. The purpose of this form is to inform you, not to alarm you. What you are being asked to sign is simply a confirmation that we have discussed the following:

ASSOCIATES AND ASSISTANTS
In this office we use trained staff personnel to assist Dr. Michael K. Van Antwerp (hereinafter, "doctor") with portions of your consultation, examination, and treatment. Occasionally when the doctor is unavailable another clinic doctor might treat you.

EXAMINATIONS
Physical Examination: Certain orthopedic, neurological, and chiropractic tests are designed to aggravate a condition in order to identify it properly. These tests have the possibility of making your condition more painful, sore, or worse, at least temporarily. These problems occur so rarely we have not been able to find available statistics to quantify their probability.

X-ray: Concerning x-ray examination, this office uses highly sensitive screens that provide the highest quality with the least exposure. This is important since certain conditions will call for the retaking of certain x-rays when circumstances warrant.

The noteworthy inherent risk with taking x-rays deals with pregnancy. If there is a possibility that you are pregnant, inform this office prior to x-ray examination. If there is no possibility of this condition, the inherent risks are so rare that we have no available statistics to quantify their probability.

TREATMENT
Manipulative Therapy/Adjusting: The doctor will use his hands or a mechanical device upon your body in such a way as to move your joints. This procedure may cause an audible "pop" or "click" much as you have experienced when you "crack" your knuckles.

Acupuncture: The doctor and/or his assigns will use an electrostimulation device, low level laser, scraping tool, percussion tool, finger pressure, or very fine needles to stimulate certain acupuncture points.

There are some material risks involved in doing these, and they are as follows:

INHERENT RISKS
Pain: It is common for an adjustment as well as traction, massage therapy, exercises, acupuncture, in fact almost any treatment, to result in a temporary increase in soreness in the region being treated.

Soft Tissue Injury: Soft tissue, such as ligaments and muscles may be stretched or torn during an adjustment. The result is a temporary increase in pain. However, there are no long term effects. These problems occur so rarely we have not been able to find available statistics to quantify their probability.

Rib Fractures: The force of an adjustment might "crack" a rib. This can happen with anyone; however, it occurs most often on patients that have weakened bones from such things as osteoporosis. Osteoporosis that is severe enough can be noted on your x-rays and when detected, we proceed with extra caution. These problems occur so rarely that we have not been able to find any available statistics to quantify their probability.

Disc Herniations: Occasionally treatment will aggravate or cause a problem if the disc is in a weakened state. It is possible that surgery may become necessary for correction, but again these problems occur so rarely that we have not been able to find available statistics to quantify their probability.

Stroke: Even though strokes happen with some frequency in our world, strokes resulting from a chiropractic adjustment are rare. This is so rare that you have the same chance of getting hit by lightning, which is around one in a million. However, this office feels that these great odds can be further reduced by tests performed in this office. Prior to treatment you will be given such tests to further reduce your risk.

Physical Therapy Burns: Some of the machines we use generate heat. We also use ice in the office. Since everyone's skin has different sensitivity to these modalities, we test our patients for sensitivity deficiencies prior to therapy use. If a burn is obtained,

there will be a temporary pain and possible blistering. This should be reported to the doctor. This is so rare that we have not found any statistics to quantify their probability.

Infection: Needle acupuncture has the potential to cause infection. However, we adhere to clean needle technique including sealed sterile disposable needles which greatly reduce the risk of infection. The literature is still unclear about risk, but it has been estimated at the low rate of less than 1 in 10,000.

Puncture: Needle acupuncture has the potential to cause mechanical injury to the lungs, heart, blood vessels, muscles, spine, and/or nerves. Penetration has to be fairly deep to cause damage which is why we use shallow needle technique and avoid contraindicated areas. Risk statistics are still unclear, but it has been estimated at the low rate of less than 1 in 10,000.

Other Problems: There may be other problems or complications that might arise from treatment, such as massage, traction, etc., other than noted above. Temporary nausea, dizziness, fainting, pain, and bruising might occur from chiropractic treatment. Temporary nausea, dizziness, fainting, pain, bruising, and local bleeding might occur from acupuncture treatment. These other problems or complications occur so rarely that it is not plausible to anticipate and/or explain them all in advance of treatment.

OTHER AVAILABLE TREATMENT

Medication: Medication may be used to relieve pain and swelling. However, medication can mask progress and the efficiency of chiropractic treatment. Caution should be used since the danger of side effects and damage to the health of a person taking the medication is well documented.

Hospitalization: Hospitalization has proven expensive and dangerous. The documentation of such is overwhelming.

Surgery: Surgery is always a possibility. The expense, danger, and ineffectiveness of such treatment is more a probability than a possibility.

NON TREATMENT

Remaining untreated, results in adhesions, pain, and reduction in associated joint mobility. The probability that these adhesions will interfere with the motion, function, and enjoyment of life is very high.

PATIENT HEALTH INFORMATION ("PHI")

Our office uses open adjusting and treatment rooms. The possibility that one's adjustment, treatment, and/or name may incidentally be observed and the possibility that conversations and/or names may incidentally be overheard are terms and conditions that the patient agrees to in this office. We try to limit incidental disclosures as much as possible and adhere to minimum necessary and reasonable safeguard requirements as required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). If private room adjusting is requested, arrangements will be made. We do respect your privacy, so a private room is available for conversations if needed. Your chart notes might be handed to you to fill out. It is your responsibility to guard these as you see fit while they are in your possession.

I UNDERSTAND THE UNDESIRED RESULTS OF EXAMINATION AND TREATMENT AND HAVE GONE OVER ANY QUESTIONS I MIGHT HAVE.

I hereby authorize and direct the above named physician and assigns to provide such additional services as they may deem reasonable and necessary.

I HEREBY STATE THAT I HAVE READ OR HAVE HAD READ TO ME THIS CONSENT FORM.

A photocopy of this Informed Consent shall be considered as effective and valid as the original.

_____	_____	_____
Patient Printed Name	Patient Signature	Date
_____	_____	_____
Parent or Guardian Printed Name	Parent or Guardian Signature	Date
_____	_____	_____
Witness Printed Name	Witness Signature	Date