COVID-19 INFORMED CONSENT TO TREAT

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

To proceed with receiving care, I confirm and understand the following (Initial in all seven places provided) **Initial Below**

- I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted. _____
- I understand that I am opting for an elective treatment that may not be urgent or medically necessary, and that I have the option to defer my treatment to a later date. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. _____
- I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care office. _____
- I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:
  *Fever *Dry Cough *Sore Throat
  *Shortness of Breath *Runny Nose *Loss of Taste or Smell _____
- I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT in the past 14 days I have not traveled: 1) Outside of the United States to countries that have been affected by COVID-19; or 2) Domestically within the United States by commercial airline, bus, or train. _____
- I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care. _____ _____
- I have been offered a copy of this consent form.

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Patient Signature: _____	Parent / Guardian Signature _____	Witness Signature _____	
Name _____	Name _____	Name: _____	
Date _____	Date _____	Date: _____	

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Patient Intake Form

Date:_____

PERSONAL HISTORY

Name:_____ Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone #:_____

Birth Date:_____ Age:_____ Sex: ____M ____F Social Security #:_____

Email:_____

Circle one: Married Single Widowed Divorced Separated

Business Employer:_____ Type of Work:_____

Business Phone:_____ Who referred you to this office:_____

Name and Number of Emergency

Contact:_____Relationship:_____

CURRENT HEALTH CONDITION

Reason for visit:_____

Other Doctors seen for this condition: ____Yes ___No Who?_____

When did this Condition begin?_____ Has this condition occurred before? ___Yes ___No

Is Condition: ___Job Related ___Auto Accident ___Home Injury ___Fall

___Other:_____

Date of Accident:_____ Time of Accident:_____

Have you made a report of your Accident to your Employer: ___Yes ___No Insurance Company ___Yes ___No

Current Medications

_____

_____

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Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

Check any of the following diseases you have had:

___Influenza
___Pneumonia
___Rheumatic Fever
___Polio
___Tuberculosis
___Whooping Cough
___Anemia
___Measles
___Mumps
___Small Pox
___Chicken Pox
___Diabetes
___Cancer
___Heart Disease
___Thyroid
___Pleurisy
___Arthritis
___Epilepsy
___Mental Disorders
___Lumbago
___Eczema

Check any of the following you have had in the past 6 months:

Musculo-Skeletal:

___Low Back Pain
___Pain between Shoulders
___Neck Pain
___Arm Pain
___Joint Pain/Stiffness
___Walking Problems
___Difficulty Chewing/Clicking Jaw
___General Stiffness

Nervous System:

___Nervous
___Numbness
___Paralysis
___Dizziness
___Forgetfulness
___Confusion/Depression
___Fainting
___Convulsions
___Cold/Tingling Extremities
___Stress

General:

___Fatigue
___Allergies
___Loss of sleep
___Fever
___Headaches

Genito Urinary:

___Bladder trouble
___Painful/Excessive Urination
___Discolored Urine

Gastro-Intestinal:

___Poor/Excessive Appetite
___Excessive Thirst
___Frequent Nausea
___Vomiting
___Diarrhea
___Constipation
___Hemorrhoids
___Liver Problems
___Gall Bladder Problems
___Weight Trouble
___Abdominal Cramps
___Gas/Bloating After meals
___Heartburn
___Black/Bloody Stool
___Colitis

C-V-R:

___Chest Pain
___Short Breath
___Blood Pressure Problems
___Heart Problems
___Stroke
___Lung Problems/Congestion
___Varicose Veins
___Ankle Swelling

EENT:

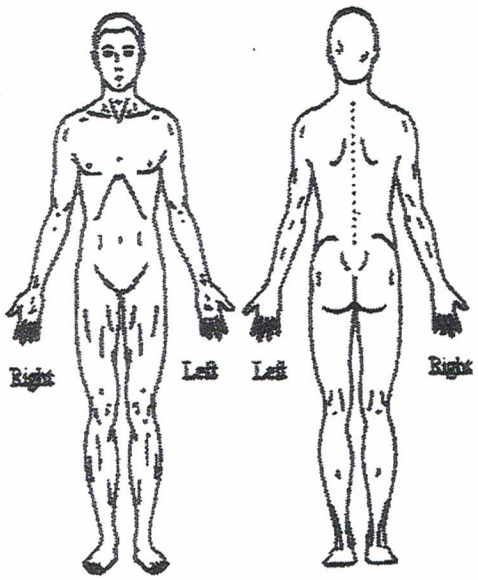
___Vision Problems
___Dental Problems
___Sore Throat
___Ear Aches
___Hearing Difficulty
___Stuffed Nose

Male/Female Code:

___Menstrual Irregularity
___Menstrual Cramps
___Vaginal Pain/Infection
___Breast Pain/Lumps
___Prostate/Sexual Dysfunction

Females Only:

When was your last period?_____
Are you Pregnant? ___Yes ___No



Please indicate on the diagram the area of your discomfort.

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INFORMED CONSENT FOR CHIROPRACTIC CARE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have both the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science of art which concerns itself with the relationship between structure (primarily of the spine) and function (primarily of the nervous system) as that relationship may affect the restoration and preservation of health. *Health is a state of optimal physical, mental, and social well- being, not merely the absence of disease or infirmity.*

One disturbance of the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 movable vertebra in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is a specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is specific adjustments to the spine. Adjustments are usually done by hand, but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek services of another health provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks, and alternatives to chiropractic care have been explained to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____ _____

Print Name Signature Date

Consent to evaluate and adjust a minor child:

I, _____, being the parent or legal guardian of

_____

have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

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AUTHORIZATION FOR DIRECT PAYMENT TO DOCTOR

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to the above named health care facility for any outstanding balances accrued as a result of the care I received. If my current policy prohibits direct payments to doctors, then I hereby also direct and instruct you to mail it to me c/o said healthcare facility. I further understand that the professional or medical expense benefits allowable and otherwise payable to me under the current policy are payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, and balance of said professional service charges over and above this insurance payment. A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

Patient Signature: _____

Witness: _____ Date: _____

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Hardship Agreement

To Whom It May Concern:

By my signature below I am requesting that my doctor reduce normal and customary fees charged as to allow me to receive chiropractic care. My financial circumstances are such that is I were to pay customary fees charged I would be forced (due to economic reasons) to not receive care.

I recognize that any agreement made to assist me is purely confidential and that my fee arrangement would be different than that which is standard in the office.

If my insurance company policy demands full payment of the deductible or co-payments, I agree that it is my responsibility to notify my insurance carrier that due to economical hardship I am only making partial payment.

_____

Signature of Patient

_____

Print Patient's Name

_____

Witness

_____

Date