Turning Leaf Chiropractic — Reactivation Health Profile

Personal Information

Name: _____ Date:_____

Date of Birth: _____

Change of address since last visit: Most recent visit at TLC:_____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Email Address: _____

Have you been to a chiropractor since your last visit at TLC? Yes No

If yes, what was the reason for those visits? _____

Chiropractor's name? _____ Date of last visit? _____

Part 1: Current Health

Describe the purpose of this visit: Wellness New Injury Chronic Condition Other

Please Explain: _____

Are you looking for: ☐ Relief Care ☐ Corrective Care ☐ Wellness Care

Is this visit related to: (circle all that apply)

Job Sports Auto Fall Home Injury Chronic Discomfort Other

Please Explain: _____

Does this condition interfere with (circle all that apply)

Work Sleep Daily Routine Other

Please Explain: _____

When did this condition begin? _____

Has the condition (circle one)

Gotten Worse Stayed Constant Comes and Goes

Since your previous visit at TLC, have you had:

(circle all that apply)

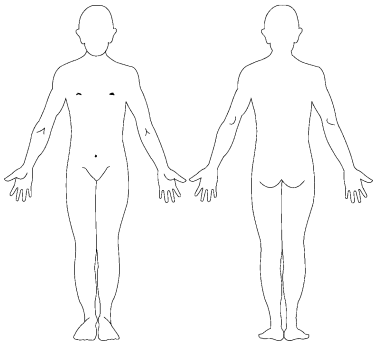
Auto Accident Surgery Work Injury

Newly Diagnosed Medical Conditions

Please explain: _____

_____

Please indicate areas of pain or discomfort:



I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed to in writing. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I clearly understand that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered to me will be immediately due and payable.
I authorize the use of this signature on any insurance submissions.

Signature: _____ *Date:* _____

AUTHORIZATION FOR CARE

I hereby authorize the doctors in this chiropractic office and whomever they may designate as their assistant to administer chiropractic care, to work with my condition through the use of adjustments and procedures the doctor deems appropriate. The Dr. will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a person for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. 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 of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of 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 ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnose or treatment for those findings, we will recommend that you seek the services of a health care provider that 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 subluxations.

*I,*_____ *have read and fully understand the above statements.*
(Print name)

All questions regarding the doctors' objectives pertaining to my care in this office have been answered to my complete satisfaction.
I therefore accept chiropractic care on this basis.

_____ _____
(Signature) (Date)

Turning Leaf Chiropractic, P.A.- 10440 185th Street West – Lakeville, MN 55044 952-898-0525

PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent only needs to obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at anytime during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Patient Signature Date