Axis
FAMILY CHIROPRACTIC, P.A.

Chiropractic Patient Update

Name _____ Date_____
Address _____ Phone (c)_____(w)_____
City, State, Zip_____ Email_____

HEALTH INSURANCE

Has your Health Insurance changed since your last visit? ○ Yes ○ No If Yes, Company:_____
Please provide us with your new insurance card when you submit your chiropractic patient update form.

AUTHORIZATION AND RELEASE

I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other health care providers and payers and to secure payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of my insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for purpose of treatment, payment, health care operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

CURRENT HEALTH CONDITIONS

Is this the same problem you were originally under care for? ○ Yes ○ No
If yes, are there any additional symptoms?_____
Briefly tell us the reason for your visit today_____
Pain or Problem started on_____ Pain is: ○ Sharp ○ Dull ○ Constant ○ Intermittent
What activities aggravate your condition/pain?_____
What activities lessen your condition/pain?_____
Is condition worse during certain time of the day?_____
Current Pain Level (0-none, 10-worst)_____ Pain Level at its Worst (0-10)_____
Is this condition interfering with ○ Work? ○ Sleep? ○ Other:_____ Is it getting worse? ○ Yes ○ No
Other doctors seen for this condition_____
Any home remedies?_____ Are you currently pregnant? ○ Yes ○ No
Any other health changes since your last visit? ○ Yes ○ No If yes, explain:_____

As a result of my chiropractic care, I would like to (check all that apply)

○ Feel better quickly
○ Have a healthier body by keeping my nerve system healthy
○ Have a healthier spine
○ Live a healthier lifestyle

I attest that all of the above and following information on this form is true to the best of my knowledge.
Patient's Signature_____ Date_____
Guardian's Signature Authorizing Care_____ Date_____

921 W. New Hope Dr, Suite 701 Cedar Park, Tx 78613
512-259-7900

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Informed Consent

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 method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as the patient, to be informed about the condition of your health and the recommended care and treatment provided so that you may make a decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

CHIROPRACTIC is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservations of health. HEALTH is a state of optimal physical, mental, and social well-being, not merely absence of disease or infirmity. One disturbance to the nervous system is called vertebral subluxation. This occurs when one or more of the 24 vertebra in the spinal column become misaligned and/or do not move properly. This causes alteration of the 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 the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method is by specific adjustments of the spine. Adjustments are usually done by the hand but may be performed by handheld instruments. I understand and consent to the following procedures: examination, x-rays (if needed), neck, spine, and extremity adjustments, joint mobilization, massage therapy, soft-tissue therapies, instrument assisted soft tissue therapy, physical therapies, hot/cold therapies, traction and/or other procedures recommended for my condition.

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reports secondary to chiropractic care include sprain/ strain injuries, irritation to a disc or nerve, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate of 1:6 million cervical spine (neck) adjustments may be vertebral artery injury that could lead to stroke. Alternative to chiropractic care may include medications, surgery, and other alternative treatments.

I have had the opportunity to discuss with, **Natalie Griffith, DC,** the various types of treatment as described above which have been proposed to me for my condition. I understand the results are not guaranteed for my condition. This consent includes all doctors of chiropractic employed at this office now or in the future, chiropractic assistants, and licensed massage therapists that are employed by, associated with or serve as back for **Natalie Griffith, DC,** whether or not their names are listed on this form. I have had the opportunity to read this form, understand the above statements, accept risks mentioned and herby consent to chiropractic treatment over the entire course of treatment for my present condition and any future condition for which I seek treatment.

Print Name:_____ Signature:_____ Date:_____

Consent to Evaluate and Adjust a Minor Child: (under the age of 18)

I,_____ being the parent or legal guardian of _____ have fully read and understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release: This is to certify that to the best of my knowledge I am not pregnant and the doctor has my permission to perform an x-ray evaluation. I have been advice that x-rays can be hazardous to an unborn child.

Date of Last Menstrual Cycle:_____ Signature:_____ Date:_____

OFFICE/ WITNESS SIGNATURE:_____ Date:_____

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Privacy Practices

I have received and reviewed the Privacy Practice Notice for Axis Family Chiropractic, and understand the situations in which this practice may need to utilize or release my medical records. I also understand that:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my Protected Health Information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its healthcare operations. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. I understand that, and consent to, the following appointment reminders that will be used by the Practice:
    a. A postcard mailed to me at the address provided by me and/or
    b. Telephoning my home and leaving a message on my answering machine or with the individual answering the phone.

3. I understand that I have the right to revoke this consent, in writing to Natalie Griffith, DC c/o Axis Family Chiropractic, PA 921 W. New Hope Drive Suite #701 Cedar Park, Tx 78613, at any time, for all *future* transactions and if I revoke this consent at any time, the Practice has the right to refuse to treat me.

4. I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in the privacy practices statement.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand. The undersign does herby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPPA, the HIPPA Compliance Manual, State and Federal Law:

Patient Signature:_____ Date:_____

If patient is a minor or under guardianship order as defined by State Law:

By_____
Signature of Parent/Guardian (circle one)