Welcome to Whole Life Chiropractic, L.L.C

Please review and sign the Practice information and Policies below.

Whole Life Chiropractic is happy to welcome you to the office. In today's ever changing, fast paced world we all juggle an incredible list of responsibilities. It is important that our health be a priority along the way. Everyone at Whole Life Chiropractic is thankful you have chosen us to partner with you in restoring and maintaining optimal health so that you may LIVE your WHOLE LIFE.

The Clinic

Whole Life Chiropractic, L.L.C. specializes in wellness care, acute injury care, athletic performance & injury care, pediatrics and pre/post-natal care. We also offer myofascial therapy (Instrument assisted and manual release technique), kinesio-taping and nutritional supplements. Dr. Nicole is a state licensed, board certified chiropractor by the MN Board of Chiropractic Examiners. She has additional training in the techniques listed above, in addition to first responding, CPR and first aid. *She is available, on- call, for home or birth center visits ~ ask for details!*

Appointments/Scheduling

Appointments can be made online via the website: www.wholelifechiro.biz. In addition, appointments can be made by phone or email.

Payment

Payment is due at the time of service. **We do not bill health insurance on your behalf.** A superbill can be provided upon request for your own submission under your "out-of-network benefits". In the unfortunate case that you are involved in a motor vehicle collision, we will gladly bill your auto insurance on your behalf. Whole Life Chiropractic accepts cash, checks, credit card and Health Savings Account (HSA)/Flex Spending Accounts (FSA) cards. Emergency visits outside of office hours or off location (home or labor visits) will be charged at the rate of $125 per visit within a 20-mile radius. This fee will not be deducted from or considered part of any package of visits that you may have previously purchased. Standard mileage fees outside 20-mile radius will be charged.

Cancellation Policy

As a courtesy to all our patients, we strive to maintain a smooth and efficient operation so that you can enjoy your treatment on time, all the time. Since our services are by appointment only, please make yourself familiar with our cancellation policy.

☐ 24-hour notice is **required** for cancelling or rescheduling an appointment to avoid charges.

☐ A late cancellation will result in a $35.00 charge. A "no call, no show" will result in a $40.00 charge.

☐ Emergencies and certain exceptions can be made on a case-by-case basis, but must be done by phone (call or text message) or email **before** the appointment.

HIPAA

The Health Insurance Probability & Accountability Act (HIPAA) of 1996 is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, the right to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared an explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your information. Whole Life Chiropractic's HIPAA privacy policies are available to read and print on our website. Please ask if you would like a copy to read upon your visit to our clinic.

Please sign your name and date below to acknowledge that you have read and understand Whole Life Chiropractic's Practice Information, Cancellation Policy, and Notice of Privacy Practices.

____ Signature

____ Date

____Relationship to Patient (if applicable)

CHIROPRACTIC INFORMED CONSENT TO TREAT

We believe that our patients should be active participants in their care. Please feel free to ask any questions about your treatment so that you may continue to make informed, responsible decisions regarding your health care. In addition, we encourage all our patients to discuss their treatment with their primary care physician. Just as the body works as an integral whole, so must the people who help you to care for it.

_____ (initial) We do not offer to diagnose or treat any disease or condition other than vertebral subluxation (spinal misalignment). However, if during your chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health provider who specializes in that area.

_____ (initial) You have the right to be informed about your condition and the recommended procedure(s) to be used so that you can make an informed decision whether to undergo the procedure after knowing the risks and hazard involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure. Doctors of Chiropractic, Medical Doctors and Physical Therapists using manual therapy treatment in the cervical spine (neck) are required to explain that there have been rare cases of injury to a vertebral artery as a result of treatment. Such an injury has been known to cause a stroke, sometimes with serious neurological damage. The rare chance of this happening is estimated to be approximately from 1 per 400,000 treatments to 1 per 10 million treatments. Appropriate tests will be performed to help identify if you may be susceptible to this type of injury; you will be notified if that is the case. If you have any questions about this, please do not hesitate to speak with your practitioner. As with any health procedure, complications may arise during treatment. These complications may include soreness, increased pain, muscle/ligament strain, dislocations, fractures, or disk injuries. These are *extremely* rare occurrences.

_____ (initial) I hereby request and authorize the performance of diagnostic tests, procedures and treatment deemed necessary by personnel involved in my care. I consent to the performance of chiropractic adjustments and other procedures within the scope of chiropractic practice within the State of Minnesota on me (or on the patient named below, for whom I am legally responsible) by the chiropractor(s) and/or other licensed chiropractor who now or in the future treat me while employed by, working or associated with or serving as back-up for the chiropractor of Whole Life Chiropractic, whether signatories to this form or not.

_____ (initial) I understand that methods of treatment may include, but are not limited to chiropractic adjustments, kinesio-taping/Rock-Tape, myofascial/trigger point therapy and nutritional counseling. The nutritional supplements, essential oils, or homeopathic remedies that have been recommended are traditionally considered safe. Supplements may have side effects including, but not limited to, gastrointestinal disturbances, headache, and rashes. I will notify my practitioner of any side effects associated with the consumption of the recommended supplements.

_____ (initial) I do not expect my provider to be able to anticipate and explain all possible risk and complications of the treatment and I wish to rely on my provider to exercise judgment during treatment. I understand that results are not guaranteed.

FEMALE ONLY

_____ (initial) I understand that it is my responsibility to inform my practitioner if I am pregnant, believe I may be pregnant or have had any complications stemming from a pregnancy.

Authorization to Treat a Minor (under the age of 18)

I hereby request and authorize my doctor at this clinic to perform diagnostic tests and render chiropractic adjustment and other treatment to my minor son/daughter. As of this date, I have legal right to select and authorize health care services for the minor child named above. Under the terms and conditions of my divorce (if applicable), separation or other authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in anyway, I will immediately notify Whole Life Chiropractic.

By signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of chiropractic adjustments and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Signature ____ Date ____

Relationship to patient (if applicable)____