SACRED TOUCH CHIROPRACTIC

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PREGNANCY PATIENT INFORMATION

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. We look forward to working with you to build better health for you and your family.

Patient Information

Full Name: _____ Date: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email _____

Date of Birth: _____ Age: _____

Marital Status: _____ # of children: _____

Emergency Contact: _____

Phone: _____

Who can we thank for referring you to our office? _____

Health Information

Reason for contacting our office:

1. _____
2. _____
3. _____

Date of Last Physical Exam: _____ Doctor: _____

Date of last menstrual cycle: _____ Due Date: _____

Have you seen any other doctors for this? (___) Yes (___) No (___) MD (___) DO (___) DC

Results: _____

List surgical operations and years: _____

_____

Medications you now take:

(___) Antidepressants (___) Pain killer (___) Muscle Relaxant (___) Amphetamine (___) Insulin

(___) Tranquilizers (___) Birth Control Pills (___) Other _____

Have you been in an Auto Accident? (___) Past Year (___) 5 years (___) Over 5 years (___) Never

If so, describe accident: _____

_____

Do you have or have you ever had (circle all that apply):

Headaches	Neck Pain	Back Pain
Dizziness	Nervousness	Digestive Disorders
Arthritis	Neuritis	Sinus trouble
Asthma	Diabetes	Heart trouble
Osteoporosis	Bleeding disorder	Nervous disorder
High Blood Pressure	Cancer	HIV +

Other – please explain: _____

_____

Family Health Information: May health problems are the result of hereditary spinal weakness; this information about your family members will give us a better understanding of your total health picture.

Name	**Relation**	**Past/Present Health Problems**

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____ Date: _____

CHIROPRACTIC WELLNESS CARE

In order for us to be able to better serve you, we would like you to understand what will take place during care with us. Our Mission is to educate and adjust as many families as possible toward optimal health through natural and unique chiropractic care.

New Patient Visit - your first visit will consist of a one-hour in-depth consultation, which will include x-rays (for non-pregnant patients). You will get an adjustment and traction if appropriate. Our initial consultation is **$150.00**.

When X-rays are taken, we will review your solution report. You will receive a copy of this solution report for your records. Due to the seriousness of this report, your spouse, or the person who helps you with your health and financial decisions, we suggest to be present. We have this policy so you will have support in making this most important health care decision and for you to thoroughly understand your condition and how we can help you. We look forward to working with you.

Welcome to our chiropractic family!

_____ We at Sacred Touch Chiropractic (STC) understand that situations may arise that requires you to cancel your appointment; however, we do require a 24-hour notice of such cancellation. We may charge a **$65.00** fee or **apply the visit to your care plan**, for any appointments that have not been cancelled within this time frame.

_____ Our Mindbody software does retain your cc information securely. If there is a payment that is owed such as a no-show we will charge your card for the amount due.

_____ We have created care plans based on your commitment of achieving and maintaining your wellness. Please review our Wellness Care Plans and let us know which plan is best for you. We offer AutoPay to assist you with your payments.

_____ We are happy to supply you with a copy of your medical records; however, this service is subject to a **$25.00 processing fee**. We require patients to complete a Medical Release form. After the form is completed and the fee is paid, please give our staff up to 7 business days to get these records together. We can fax medical records through a secure fax line to another medical provider.

_____ If you stop your treatment plan for longer than 90 days your Care Plan is void and the Standard Visit fee will be charged. If you resume your care after the 90 days there will be a **$65.00 Returning Patient fee** before reinstating your Care Plan. **If you have not seen longer than 3 years, this plan will be no longer valid.**

_____ Payment is due at time of visit. Sacred Touch Chiropractic is willing to work with you on a payment plan. All payment plans need to be on Auto Pay. We will assign all accounts (30) days or more past due to an outside collection agency. This may be an automatic assignment unless management has approved prior arrangements.

Patient Signature: _____ Date: _____

Patient Name: _____

DOCTOR – PATIENT RELATIONSHIP IN CHIROPRACTIC

Chiropractic

Chiropractic is a health care discipline, which emphasizes the inherent recuperative power of the body to heal itself without the use of drugs or surgery. The practice of chiropractic focuses on the relationship between structure (primarily the spine) and function (as coordinated by the nervous system) and how that relationship affects the preservation and restoration of health. In addition, Doctors of Chiropractic recognize the value and responsibility of working in cooperation with other health care practitioners when in the best interest of the patient.

Analysis

A Chiropractor conducts a clinical analysis for the express purpose of determining whether there is evidence of *Vertebral Subluxation Complexes (VSC).* When such complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no physician can promise you specific results. This depends upon the inherent recuperative powers of your own body.

Diagnosis

Chiropractors are experts in diagnosing the Vertebral Subluxation Complex but are not internal medical specialist. Every Chiropractic patient should be mindful of his/her own symptoms and express any change in their condition to their physician. Together the patient and physician can evaluate the situation and determine an appropriate course of action. The chiropractor, being a primary health care provider has a network with other health care professionals and if warranted may advise a referral. The STC patient is ultimately responsible for his or her own health care.

Informed Consent for Chiropractic Care

A patient, in coming to the chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the Chiropractic tests, diagnosis, and analysis. The chiropractic adjustment and procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or health care, if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make It known or to learn through health care procedures whatever he is suffering from: latent pathological defects, illness, or deformities which would otherwise not come to the attention of the Chiropractor. The patient should look to the correct specialist for the proper diagnosis and procedures. The Chiropractor provides a specialized, non-duplicating health service. The doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

Results

The purpose of Chiropractic services is to promote natural healing through the reduction of the Vertebral Subluxation Complex. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the Chiropractic procedures. Sometimes the response is phenomenal. In most cases there is a more gradual, but satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same Chiropractic care. Many medical failures find quick relief with Chiropractic care. In turn, we must admit that conditions, which do not respond to chiropractic care, may come under the control of or be helped through medical science. The fact is that the science of Chiropractic and Medicine may never be so exact as to provide definite answers to all problems. **Both** have achieved great strides in alleviating pain and controlling disease.

Chiropractic doctors do not treat disease; they adjust subluxations to remove nerve interference, thus allowing the body to improve its function and heal itself.

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 of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

HIPPA Laws

Due to HIPPA Laws – Please refrain from talking on your cell phone in this office. No picture taking allowed.

Photograph/Video Release

_____ I give my permission for Dr. Dawn Tames to use my (and my children) photographs on Sacred Touch Chiropractic / Dr. Dawn Tames marketing material and social networking sites (website, Instagram, Facebook, Yelp, etc). These photographs will be used exclusively for that purpose and will not be shared with anyone else I have the right to have my photograph taken off the website at any time upon my written request.

Credit Card Authorization

_____ I understand and authorize that my credit/debit card will be on file. If I have an outstanding balance this credit/debit card will be used for those fees. I may cancel this authorization at any time.

Patient Name: _____

Patient Signature: _____ **Date:** _____