Wholesome Health and Wellness

info@wholesomehealthandwellness.com (770)313-8816

Welcome to Wholesome Health and Wellness, we are so pleased you have chosen us for your health care needs. The following policies and procedures will help you get acquainted with us.

- Chemical Sensitivity- Please be considerate of our chemically sensitive patients. We ask that you refrain from using perfumes, heavy deodorants, and Nicotine/Smoke prior to your scheduled appointments.
- Supplement/Vitamin Policy- Refunds accepted on unopened supplements within one (1) week of purchase. NO Refunds on opened supplements.
- Supplement purchases are only for our current patients. We will not dispense supplements to a patient that is inactive for three months or more.
- All payments are due at the time of service and we are out of network for all providers.

Patient Signature: _____ Date: _____

PATIENT INFORMATION:

NAME: _____DATE:_____

ADDRESS: _____

CITY: _____ STATE:_____ ZIP CODE: _____

E-MAIL: _____ PHONE: _____

DATE OF BIRTH: _____ PLACE OF BIRTH: _____

HEIGHT: _____ WEIGHT: _____ GENDER: _____

MARITAL STATUS: _____ CHILDREN: _____

OCCUPATION: _____ EMPLOYER: _____

EMERGENCY CONTACT: _____ PHONE: _____

RELATIONSHIP TO PATIENT: _____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

_____

DO YOU HAVE MEDICARE OR MEDICAID HEALTH INSURANCE? _____

INFORMED CONSENT:

Patient Name:

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by Ashleigh Deibel, D.C. and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for Ashleigh Deibel, D.C., including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not. I have had an opportunity to discuss with the Ashleigh Deibel, D.C. and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed, and there is no promise of cure.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

The probability of those risks occurring are rare. Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination. Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

Other treatment options for your condition may include: Self-administered over-the-counter analgesics, rest, medical care, prescription drugs such as anti-inflammatory, muscle relaxants, and pain-killers, hospitalization, and surgery. If you choose to use one of the above noted "other treatment" options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

CONSENT TO TREATMENT (MINOR) I hereby request and authorize Ashleigh Deibel, D.C. to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter: _____. This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion. As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal 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 any way, I will immediately notify this office.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatments. I have had the opportunity to discuss the above treatments and risks with Ashleigh Deibel, D.C. and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient's Name:

_____

Signature:

_____

Guardian Signature (if a minor):

_____

Date:

_____

FEE SCHEDULE:

30 Minutes - $150

1 Hour/ New Patient Appointment - $300

PAYMENT AGREEMENT:

I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment at the time of service. I understand and agree that all services and products are out of pocket and Wholesome Health and Wellness is out of network for all insurance providers and I am responsible for submitting for all insurance reimbursement filings. I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I further understand that if I fail to pay this bill and it is turned over to an attorney or (collection agency) for collections that I will be responsible for all legal fees, court fees and collection agency fees. I have read and consent to all fees for treatments rendered in this office.

Name of person responsible for payment:

_____

Patient/Guardian Signature:

_____

Date:

_____

MISSED APPOINTMENT POLICY:

At Wholesome Health and Wellness, we respect our patients and appreciate the mutual courtesy in return by canceling or rescheduling all appointments at least 48 hours prior to the regularly scheduled time. If there is a failure to do so there will be a missed appointment fee charged to the patient. The missed appointment fees are as follows:

30 Minute - $ $75
1 Hour/New Patient Appointment- $150

I have read understand I am responsible for missed appointment fees if I do not cancel or reschedule at least 48 hours in advance.

Print Name:

_____

Signature:

_____

Date:

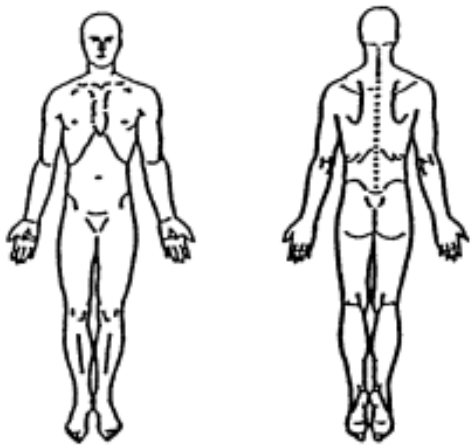
_____

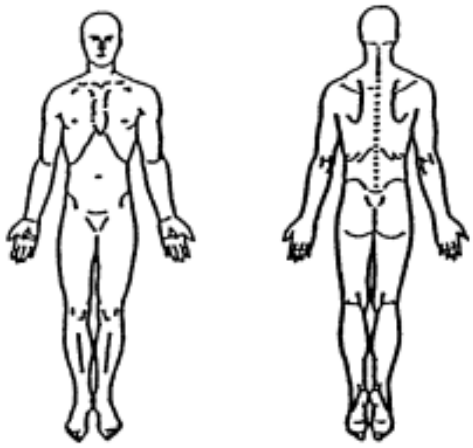
HISTORY OF INJURIES

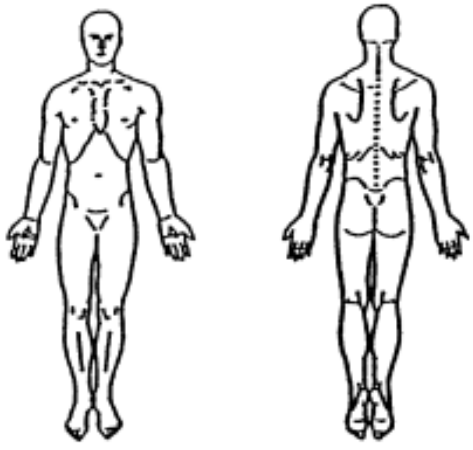
NAME_____ **DATE**_____

PLEASE MARK ALL PLACES THAT HAVE EVER BEEN INJURED

Sprains/Strains, Broken Bones, Severe Bruises, Surgery, Scars, Head Bumps, Cuts, Burns, Etc.







What happened?	When did it happen?
What happened?	**When did it happen?**
What happened?	**When did it happen?**

Please fill out all the information below as completely as possible. It is essential that this office has all the information about your medical history available so that an accurate diagnosis may be made.

Doctor(s) Name	Phone Number	Address
1.		
2.		

Current Medications	Medication Allergies
1.	1.
2.	2.
3.	3.

Food Allergies	Other Allergies
1.	1.
2.	2.
3.	3.

Previous Illnesses		Previous Surgeries	
1.	Date:	1.	Date:
2.	Date:	2.	Date:
3.	Date:	3.	Date:
4.	Date:	4.	Date:
5.	Date:	5.	Date:
6.	Date:	6.	Date:

What Is Your Chief Complaint?

Date When Chief Complaint Began: / /

What Caused It?

Is The Pain Constant Or Intermittent?

DESCRIBE THE QUALITY OF PAIN: Mark all that apply:

Sharp ( ) Dull ( ) Stabbing ( ) Aching ( ) Tingling ( ) Burning ( ) Numbing ( ) Radiating ( )

Is The Pain Getting Worse? Y / N

Does anything make it better? Y / N

What?

Does Anything Make It Worse? Y / N

What?

DOES IT INTERFERE WITH? (Mark All That Apply)

Work ( ) Daily Routine ( ) Sleep ( ) Other? ( )

Explain:

Have you ever had this pain before? Y / N When? What did you do?

Was this effective? Y / N

Have you had any accidents? Y/N

IS YOUR MAJOR COMPLAINT THE RESULT OF ANY TYPE OF ACCIDENT? Y/N Date of Accident / /

If so what? Work ( ) Home ( ) Automobile ( ) Other ( )

Are you now disabled from work? Y / N How long? _____

Explain:

PATIENT AND FAMILY MEDICAL HISTORY

Conditions	History* (see bottom)	Presently or How Long Ago
Anemia		
Arthritis		
Asthma		
Back Pain		
Bladder Trouble		
Cancer		
Chest Pain		
Diabetes		
Epilepsy		
Fatigue		
Headaches		
Heart Condition		
Hepatitis		
High Blood Pressure		
HIV/AIDS		
Hypo/Hyper Glycemia		
Indigestion		
Kidney Disorder		
Lung		
Mental Illness		
Menstrual Cramps		
MS/Lupus		
Neck Pain		
Numbness		
Poor Circulation		
Rheumatism		
Sexual Diseases (STD's)		
Sinus Troubles		
Stroke		
Urinary problems		
Other		

* **History:** S-Self M-Mother F-Father GP-Grandparent