Tree of Life Health Solutions

David Rohrer, M.D./ Pauletta Hummel, FNP/ Kim Lyons, D.C., N.D./ Emma Rohrer, D.C.

Patient Demographics Form

Patient:_____DOB:_____ Gender: M / F

Parents/Guardian if patient is a minor:_____

Street Address:_____

P.O. Box (if applicable): _____

City:_____ State:_____ Zip Code:_____

Home Phone: _____ Cell Phone_____

Employer:_____ Work Phone:_____

Email:_____

Name and Phone # for Spouse/ Significant Other:

_____

Emergency Contact Name/ Relationship/ Phone #:

_____

Patient Signature_____ Date:_____

Parent/ Guardian Signature (if applicable):_____

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	**YES**	**NO**
May we leave a message on your answering machine at home or on your cell phone?	**YES**	**NO**
May we discuss your medical condition with anyone?	**YES**	**NO**

If YES, please give the name and relationship of those allowed:

_____

_____

_____

Printed Name of Patient:_____

Signature:_____ Date:_____

If person signing is not the patient, name and relationship to patient:

_____

Tree of Life Health Solutions No-Show Policy Agreement

Thank you in advance for complying with this policy. It allows us to keep our practice running smoothly and on time, and to provide you with the excellent care you deserve.

- **No Show** - Should you be unable to keep your appointment, you agree to provide our practice with **at least a 4 (four) hour notice** before its scheduled date and time. Messages may be left on our voicemail during or after office hours. If you ever do no-show for a scheduled appointment, you understand that you may be **charged a fee of $50 for a single provider appointment and $85 for a double provider appointment.**

- **Late Cancellation** - Should you need to cancel or reschedule your appointment you agree to provide our practice with **at least a 4 (four) hour notice** before its scheduled date and time. Messages may be left on our voicemail during or after office hours. You understand that if you do late-cancel your appointment, that you may be **charged a fee of $50 for a single provider appointment and $85 for a double provider appointment.**

- **Late Arrival** - You agree to arrive at your scheduled appointments on time. You understand that if you do show up **more than 10 (ten) minutes after the scheduled appointment time** that we may not be able to allow you to see the provider. Should this occur, we will gladly make another appointment for you at the earliest available time. Please allow adequate time for your travels and parking. Parking may be found behind our office off of Sycamore Street (marked by our business sign), available street parking, or a public parking lot is available off of Third Street on the same block as our office. All parking is free of charge. Be sure to abide by parking laws and rules.

Patient Name:_____ **Date:**_____

Parent/ Guardian (if patient is a minor):_____

Signature of Patient or Parent/ Guardian:_____

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Private Billing and Payment Contract Regarding Medicare, Medicaid, Tricare/Military, and All Insurance Plans

Definitions: **Patient and Beneficiary** are the same individual. This is the individual receiving services by the providers.

Representative: The individual responsible for health care decisions and financial responsibilities of the beneficiary/patient.

*Our providers do NOT participate with ANY Medicare, Medicaid, Tricare/Military, or Other Insurance Plans, as they have chosen to opt out of these contracts. The providers are excluded from Medicare under the Social Security Act 1156 as a personal choice in regards to all services provided at Tree of Life Health Solutions.

*The Beneficiary/Patient or his/her legal representative accepts full responsibility for payment of the providers' charges for all services furnished by them. These payments are due at the time of services, no exceptions. We accept cash, check, and credit as forms of payment. A convenience fee will be applied to all credit card transactions. This is not applied to debit or HSA debit cards. We do NOT offer payment plans.

The Beneficiary/Patient or his/her legal representative agrees not to submit a claim to Medicare/Medicaid/Tricare, nor ask the provider to submit a claim on his/her behalf. Private insurance claims may be submitted by the beneficiary or beneficiary's representative independently. To clarify, we do not submit claims for billing on behalf of patients.

*The Beneficiary/Patient or his/her legal representative understands that Medicare or Medicaid payment will not be made for any items or services furnished by the providers that would have otherwise been covered by Medicare, Medicaid, or Tricare. There is no private contract with the providers with these government services, therefore claims will not be paid to beneficiaries. This may apply to private insurance as well in regards to out-of- network providers.

*The Beneficiary/Patient or his/her legal representative is entering into this contract with the knowledge that the beneficiary has the right to obtain Medicare, Medicaid, Tricare/Military, and ALL Insurance Plans covered items and services furnished by other physicians or practitioners who have not opted out. To clarify, the patient has the right to seek healthcare by a provider that takes insurance.
* The Beneficiary/Patient or his/her representative understands that Medigap plans do NOT, and other supplemental plans may elect not to, make payments for items and services not paid for by Medicare, Medicaid, Tricare/Military, and All Insurance Plans.

* This contract is renewed at minimum every two years effective January 1st of each odd year.

Beneficiary/ Representative Printed Name:_____

Beneficiary/ Representative Signature:_____

Provider Signatures (Automatic):

David M. Rohrer, MD

Pauletta J. Hummel, FNP

Kim J. Lyons, DC, ND

Emma Rohrer, DC

Tree of Life Health Solutions Chiropractic Informed Consent Form

*** As a unique Integrative Medical Practice, we do offer in house Chiropractic Services and Modalities. There are times that our Medical Providers may refer to our Chiropractic Doctors for certain conditions. Though you are not required to see our Chiropractors, this form is to cover such instances including adjustments and/or modalities. We request *all* patients to sign this form.**

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.

The nature of the chiropractic adjustment: The primary treatment used by doctors of chiropractic is spinal manipulative therapy. The doctor may use his/her hands or mechanical instrument upon your body in such a way as to move your joints. That may cause and audible "pop" or "click." You may feel a sense of movement.

Analysis / Examination / Treatment: As part of this, you are consenting to the following procedures if applicable or recommended. Of course you have the right to refuse any of these items at any time:

Spinal manipulative therapy Palpation/Feeling Vital Signs Postural Testing

Range of Motion Testing Orthopedic Testing Basic Neurological Testing

Muscle Strength Testing Postural Analysis Testing Hot/Cold Therapy

Ultrasound and/or Electrical Stim Laser PEMF(Pulsed ElectroMagnetic Frequency)

Firefly Shockwave Diathermy Decompression Manual Therapy/Massage

The risks inherent in chiropractic adjustment: 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 may 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: Fractures are rare occurrences and generally result from some underlying weakness of the bone, which is checked for during the taking of your history and examination, which is why a complete history given by the patient is very important. 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 casual

relationship to 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.

The availability and nature of other treatment options: Other treatment options for your condition may include: Self-administered; over the counter analgesics and rest; Medical care and prescription drugs such as anti-inflammatories, muscle relaxants and pain-killers; Hospitalization; Surgery

If you chose 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.

The risks and dangers possible to remaining untreated: 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.

I have read the above or have had it read to me, regarding the above explanation of the chiropractic adjustment and related treatment. 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 potential risks, I hereby give consent to that treatment. I understand that I may ask the Providers questions in regards to any concerns.

Patient's Printed Name: _____

Signature: _____ Date: _____

Signature of Parent or Guardian(if a minor): _____

CONSENT TO TREATMENT OF A (MINOR)

I hereby request and authorize ____Dr. Emma Rohrer, DC and/or ____Dr. Kim Lyons, DC,ND to perform diagnostic tests and render chiropractic and other treatment to my minor son/daughter: _____. I certify that I have the legal right to select and authorize health care services for the minor child named above. If my authority to do so is modified or revoked in any way, I will immediately let the office know. This authorization also extends to all other doctors and office staff members.

New Patient Health History Form

Patient Name:_____ Birth Date:____/_____/_____ Date:____/____/____

Pharmacy Name and City:_____

Reason for Today's Visit:_____

Do you have a pacemaker/ ICD: □ **YES** □ **NO**

Current Illnesses/ Injuries	Prior Surgeries

Please list ALL medications (prescription and non-prescription) that you take. (Include herbal remedies, vitamins, over-the-counter, street drugs, prescriptions, etc.)

Medication/Supplement	Dosage	Medication/Supplement	Dosage

Do you take any blood thinning products such as Vitamin E, Plavix, Coumadin, or Aspirin?
□ **YES** □ **NO**

Do you have any food, environmental, or drug allergies? □ **YES** □ **NO**

Allergy	Type	Reaction

Do you smoke? □ **YES (please explain below)** □ **NO and Never have**

Type of Smoking (cigarettes, pipe marijuana, chew, etc.)	How Much?	How Long?

Do you drink alcohol? □ **NO and never have** □ **Socially Only** □ **Daily**
Occupation:_____

Continue on the next page.

Please describe any family health issue below:

Family History	Good/None	Unknown	Illnesses / Reason For Death
Mother			
Father			
Sibling(s)			
Other Hereditary Illness			

Do you CURRENTLY have or have SIGNIFICANT history of any of the following:

Symptom/ Illness	NO	YES, Explain	Symptom/ Illness	NO	YES, Explain
Constitutional			**Skin**		
Fever or Chills			Breast Abnormalities		
Weight Loss			Nipple Discharge		
Hematologic			**Last Mammogram**		**Date:**
Hepatitis			Changes in Moles		
HIV			Lesions		
Bleeding Disorders			Rashes		
Endocrine			History of Keloids		
Thyroid Problems			**Neurological**		
Diabetes			Neurological Problems		
Musculoskeletal			Headaches		
Arthritis			**Genitourinary**		
Mobility/ Joint Problems			Genital or Oral Herpes		
Gastrointestinal			STDs		
Constipation			Blood in Urine		
Diarrhea			Urinary Tract Infection		
Blood in Stool			Problems Urinating		
Nausea/ Vomiting			Prostate Problems		
Liver Problems			Kidney Problems		
Cardiovascular			**Eyes**		
Heart Problems			Vision Problems		

Symptom/ Illness	NO	YES, explain	Symptom/ Illness	NO	YES, explain
Deep Vein Thrombosis			**ENT**		
Blood Clots			Hearing Problems		
High Blood Pressure			Sinus Problems		
Respiratory			**Psychiatric**		
Asthma			Mood Swings		
Sleep Apnea			Anxiety/ Depression		

Please list any other conditions/ illnesses not indicated above:

_____

_____

To the best of my knowledge, this information is complete and correct. I understand that it is my responsibility to inform my doctor if there are any changes to my health.

Patient Signature:_____Date:___/____/___

Physician Signature:_____ Date Reviewed:___/____/____