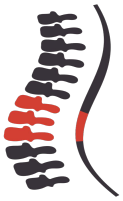
Rev. 4

DR. AUGUST
FAMILY CHIROPRACTOR



9/2025

PRACTICE MEMBER DEMOGRAPHICS Today's Date: ____/____/____

Name: _____ Birth Date ____/____/____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip _____

E-mail Address: _____ Mobile Phone: _____

Marital Status: ☐Single ☐ Married ☐ Widowed ☐ Divorced Home Phone: _____

Employer: _____ Occupation: _____

Spouse's Name: _____ Spouse's Employer: _____

Number of children: _____ Names of children (optional): _____

Name Emergency Contact: _____ Relationship: _____

Phone for Emergency Contact: _____

Whom may we thank for referring you to this office? _____

HISTORY of COMPLAINT

Current Complaints: (List according to severity)	**Rate of Severity** 1 = Mild 10 = Unbearable	**When did this episode start? Give Year**	**Did you have this condition before & when?**	**Did the problem begin with an injury?**	**Constant or intermittent?**
1.					
2.					
3.					

What problem brings you in? _____ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐late PM

How long does it last?
- ☐ It is constant
- ☐ I experience it on and off during the day
- ☐ It comes and goes throughout the week

Condition(s) ever been treated by anyone in the past? No Yes
If yes, when: _____ by whom? _____

How long were you under care: _____ What were the results? _____

Name of Previous Chiropractor: _____

What relieves your symptoms? _____

What makes your symptoms feel worse? _____

Have these symptoms affected:
- ☐ Family life
- ☐ Work
- ☐ Sleep
- ☐ Exercise
- ☐ Other: _____

Is your problem the result of ANY type of accident? ☐ Yes, ☐ No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

What are your Chiropractic Health Goals?

1) _____ 2) _____ 3) _____

STRAIGHT CHIROPRACTIC TERMS OF ACCEPTANCE

Rev. 3 6/2025

When an individual seeks straight chiropractic care, and when a straight chiropractor accepts an individual for such care, it is vital that they be seeking and working for the same goal.

Straight chiropractic has only one goal. It is, therefore, essential that the practice member understands the goal and the means that will be used to attain it. In this way, there will be no confusion, misunderstanding and/or disappointment concerning your care in this office.

Our only goal in this office is to keep your body free from vertebral subluxations. A vertebral subluxation is a misalignment of one or more vertebrae which alters nerve function. This results in a lessening of your body's ability to function as best it can. Vertebral subluxation results in a decreased human potential which straight chiropractors call a state of *dis-ease* or simply, a lack of harmony in the body.

We correct vertebral subluxations because we know that every person functions better under every circumstance when free from vertebral subluxations.

Patients usually want to get rid of whatever ailments or conditions are bothering them. However worthy a goal this may be, it is not the goal of straight chiropractic. We do not offer a medical diagnosis, treatment or cure for disease.

If, during our straight chiropractic analysis, we recognize an unusual finding that is outside the scope of straight chiropractic practice, we will:

1. Inform you immediately of the existence of the finding,
2. Record the existence of the finding,
3. Inform you that it is outside the scope of straight chiropractic practice to diagnose, prognose, treat or offer advice concerning non-chiropractic findings

This does not rule out your continuing straight chiropractic care if, in ***our*** opinion, it remains safe and in your best interest. Straight chiropractic is not a replacement or alternative to medical or any other type of health care just as other types of health care are not replacements or alternatives to straight chiropractic care.

To allow for safe and competent straight chiropractic care, we wish to maintain current records of any illnesses, surgeries, accidents or other injuries. It is your responsibility to provide all information necessary to update these records.

I/We _____ undertake straight chiropractic care for ourselves and our family with the acknowledgment and acceptance of the provisions of the above Terms of Acceptance.

Patient : _____ Witness: _____

Date: / /

DR. AUGUST

FAMILY CHIROPRACTOR

INFORMED CONSENT

For Chiropractic Care

Please read this entire section prior to signing. It is important that you understand the information contained in this section. If anything is unclear, please ask questions before you sign.

DO NOT SIGN THIS CONSENT TO BE ADJUSTED UNTIL YOU HAVE READ, UNDERSTAND AND ASKED ANY QUESTIONS YOU MAY HAVE.

Chiropractic Adjustment Risks:

As with any healthcare procedure, there are certain complications which may arise during or after chiropractic adjustments of the spine. These complications include but are not limited to**: Fractures of bones**, **Spinal disc injuries**, **Joint dislocations**, **Muscle injuries**, **Nerve injury**, **Worsening of symptoms** and **Rib injuries**. It is also typical to feel soreness after an adjustment, this soreness can last up to a week. These complications are generally described as rare.

Adjustments of the neck has been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. The incidences of stroke are exceedingly rare and are estimated to occur between one in 10 million or more neck adjustments. The number for chiropractic related fatalities is typically always zero per year.

Potential Benefits of Chiropractic and Associated Care:

The vast majority of chiropractic patients tend to achieve good to excellent improvement in their physical and emotional conditions with chiropractic care. Improvement can be measured in many different ways, including reduction in pain, increased range of motion, less stiffness, increased athletic performance, and other ways. It must be remembered that different people get different results, different people have different pre-existing conditions, and are of different ages and occupations (with different types of physical and emotional stress). Your situation is unique, and **NO** guarantees are given. You will have to determine what results you get for yourself and report them to your Doctor of Chiropractic.

Having been informed of these risk factors, I hereby attest that I understand the terms used in the above paragraphs and give my consent for chiropractic treatment.

Patient/Guardian Name Printed	Date
Patient/Guardian Signature	Relationship to Patient
	Doctor Signature

HIPAA Compliance Form

Rev. 3

Dr. August Family Chiropractor Consent for Purposes of Treatment, Payment & Healthcare Operations

6/2025

In this document, "I" and "my" refer to the patient, and "Chiropractor" refers to Dr. August Bausewein IV or Dr. August Family Chiropractor.

I consent to the use or disclosure of my protected health information by the Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of the Chiropractor. I understand that analysis, diagnosis or treatment of me by the Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The Chiropractor is not required to agree to the restrictions that I may request. However, if the Chiropractor agrees to a restriction that I request, the restriction is binding on the Chiropractor. I have the right to revoke this consent, in writing, at any time, except that the Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. The protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of the Chiropractor and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Chiropractor. The Notice of Privacy Practices for the Chiropractor is also posted in the waiting room at Dr. August Family Chiropractor. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

The Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of the Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

This office utilizes an "open-adjusting" environment for ongoing patient care, which involves several patients being seen in the same or adjacent adjusting rooms at the same time. Patients are within sight of one another, use a sign-in sheet, and some ongoing routine detail of care are discussed within the vicinity of other patients and staff. This environment is used for ongoing care NOT for case histories or reports of findings except with consent of the patient. If you so choose arrangements will be made for a non open-adjusting environment.

Your name and/or your family's names and pictures may be seen by others in connection with or on: our bulletin board, birthday listings, birth announcements, file folder labels, computer screen, referral and thank-you cards. If you choose not to have this information displayed please notify us. Generalized discussion of friends and family members may occur from time to time; however, personal health information will remain private.

_____ _____

Signature of Patient/Personal Representative

Printed Name of Patient

___ /___ /___

Date of Signing

_____

Description of Personal Representative's Authority