



Rowe Family

Chiropractic Center

Today's Date ___/___/___ **Welcome!!!!**

Name _____ DOB ___/___/___ Age ___ Male / Female (Are you pregnant? Y / N)

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email Address: _____

Marital Status: _____ Spouse's Name: _____

Children (Name and ages): _____

Height: _____ Weight: _____

Occupation _____ Employer's Name _____

Job Description: _____

Who may we thank for referring you: _____

Emergency Contact:

Last: _____ First: _____ Middle: _____

Contact phone number: _____ Relationship: _____

Primary Care Physician (name and phone number) _____

Insurance Information

Insurance Company _____ ID# _____ Group# _____

Subscriber Name _____ DOB: _____ Relation to patient _____

Current Complaints: Circle ALL current problems You Have

NECK PAIN	MID BACK PAIN	LOW BACK PAIN	HEART PROBLEMS
HEADACHES/MIGRAINES	SHOULDER PAIN	SCIATICA	THYROID PROBLEMS
DIZZINESS/VERTIGO	SCOLIOSIS	DISC PROBLEM	FIBROMYALGIA
TMJ	ASTHMA	RESTLESS LEGS	STOMACH PROBLEMS
SINUSES/ALLERGIES	FATIGUE	NUMB LEGS/FEET	LIVER/KIDNEY PROBLEM
NUMB ARMS/HANDS	SKIN CONDITIONS	PLANTAR FASCIITIS	INFERTILITY
ANXIETY/DEPRESSION	INSOMNIA	HIP/KNEE/ANKLE PAIN	BOWEL/BLADDER
ADD/ADHD/AUTISM	LOW IMMUNE SYSTEM	MENSTRUAL PROBLEMS	AUTOIMMUNE DISEASE

Primary (Chief) Complaint(s): Why are you here today?

When did this Condition/Pain **BEGIN**? _____

Has it ever occurred before? Yes No When? _____

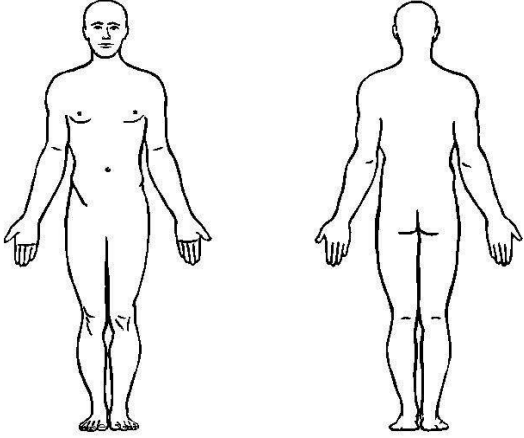
- Is the Condition: Auto Related Date: _____
 Work Related Date: _____
 Slip or Fall
 Lifting
 Slept Wrong
 Unknown Cause
 Other _____

What makes this condition better/worse?:

Don't just rate the hurt; rate how it's affecting your life!

Use the letters **BELOW** to indicate the **TYPE** and **LOCATION** of your sensations right now.

Key: A=Ache B=Burning N=Numbness P=Pins & Needles S=Stabbing



0 Pain Free	1 Very Mild	2 Discomforting	3 Tolerable	4 Distressing	5 Very Distressing	6 Intense	7 Very Intense	8 Utterly Horrible	9 Excruciating/ Unbearable	10 Unimaginable/ Unspeakable
NO PAIN	MINOR PAIN			MODERATE PAIN			SEVERE PAIN			
You are living life as per usual.	Pain does not limit your activity; you are still living a normal life with a little bit of pain added in.			Your pain is <i>somewhat</i> disabling - you might avoid activities that exacerbate it.			Your pain is <i>extremely</i> disabling. It has drastically affected your quality of life and is always on your mind.			

Previous Care for this Same Condition: I have not previously seen a doctor for this condition
 If YES by whom? _____ When? _____
 Treatment _____ Satisfied with results? YES NO
 Explain: _____

Previous Chiropractic Care: I have not previously had chiropractic care.
 If YES by whom? _____ When? _____
 Satisfied with your care? YES NO
 Explain: _____

Do you wear any of the following? Heel lifts Brace Arch supports Orthotics Other _____
 For how long? _____ Were they prescribed by a doctor? YES NO

PAST HEALTH HISTORY – Fill out carefully as these problems can affect your overall course of care.

Childhood Illness(es): Place a mark to indicate if you have had any of the following.

- | | | | |
|--|--|------------------------------------|---|
| <input type="checkbox"/> ADD | <input type="checkbox"/> depression | <input type="checkbox"/> hepatitis | <input type="checkbox"/> seizure disorders |
| <input type="checkbox"/> allergies _____ | <input type="checkbox"/> diabetes | <input type="checkbox"/> measles | <input type="checkbox"/> sickle cell anemia |
| <input type="checkbox"/> anemia | <input type="checkbox"/> ear infections | <input type="checkbox"/> mumps | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> bedwetting | <input type="checkbox"/> eczema | <input type="checkbox"/> psoriasis | |
| <input type="checkbox"/> chicken pox | <input type="checkbox"/> fetal drug exposure | <input type="checkbox"/> rash | |
| <input type="checkbox"/> Crohn's/colitis | <input type="checkbox"/> headaches | <input type="checkbox"/> scoliosis | |

Do you believe that the Adult Illness below are contributory to your CURRENT condition? YES NO

Adult Illness(es): Place a mark to indicate if you have had any of the following.

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> ADD | <input type="checkbox"/> cystic kidney disease | <input type="checkbox"/> hepatitis | <input type="checkbox"/> psoriasis |
| <input type="checkbox"/> allergies _____ | <input type="checkbox"/> depression | <input type="checkbox"/> HIV | <input type="checkbox"/> scoliosis |
| <input type="checkbox"/> anemia | <input type="checkbox"/> diabetes (insulin dependent) | <input type="checkbox"/> hypertension | <input type="checkbox"/> seizures |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> diabetes (non-insulin) | <input type="checkbox"/> influenza pneumonia | <input type="checkbox"/> shingles |
| <input type="checkbox"/> asthma | <input type="checkbox"/> eczema | <input type="checkbox"/> liver disease | <input type="checkbox"/> STD |
| <input type="checkbox"/> cancer _____ | <input type="checkbox"/> emphysema | <input type="checkbox"/> lung disease | <input type="checkbox"/> suicide attempt(s) |
| <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> lupus | <input type="checkbox"/> vertigo |
| <input type="checkbox"/> chicken pox | <input type="checkbox"/> heart disease | <input type="checkbox"/> multiple sclerosis | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Crohn's/colitis | | <input type="checkbox"/> Parkinson's disease | |
| <input type="checkbox"/> CVA (Stroke) | | <input type="checkbox"/> Pneumonia | |

Current Medication(s): List ANY/ALL medications you are CURRENTLY taking. Be specific.

Medication	Dosage	For what condition?	For how long?

Current vitamins, Herbs, etc.: List ANY/ALL non-prescription items you are CURRENTLY taking. Be specific.

Name	Dosage	For what condition?	For how long?

Surgery(ies): List All procedures. Write the DATE of procedure immediately afterward.

- | | | |
|--|---|--|
| <input type="checkbox"/> angioplasty _____ | <input type="checkbox"/> cosmetic _____ | <input type="checkbox"/> mastectomy _____ |
| <input type="checkbox"/> appendectomy _____ | <input type="checkbox"/> D&C _____ | <input type="checkbox"/> pacemaker insertion _____ |
| <input type="checkbox"/> caesarian section _____ | <input type="checkbox"/> dental surgery _____ | <input type="checkbox"/> rotator cuff _____ |
| <input type="checkbox"/> cardiac catheterization _____ | <input type="checkbox"/> gall bladder _____ | <input type="checkbox"/> spinal surgery _____ |
| <input type="checkbox"/> carpal Tunnel repair _____ | <input type="checkbox"/> hernia repair _____ | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> coronary artery bypass _____ | <input type="checkbox"/> hysterectomy _____ | |
| | <input type="checkbox"/> joint reconstruction _____ | |
| | <input type="checkbox"/> joint replacement _____ | |

Trauma: Please list ALL injuries. Write the DATE of the injury immediately afterward.

- | | | |
|--|---|--|
| <input type="checkbox"/> back injury _____ | <input type="checkbox"/> head injury _____ | <input type="checkbox"/> work injury _____ |
| <input type="checkbox"/> disability(ies) _____ | <input type="checkbox"/> joint injury _____ | |
| <input type="checkbox"/> fracture(s) _____ | <input type="checkbox"/> motor vehicle injury _____ | |

Family history: Mark ALL that apply below. List any specific conditions past or present after has/had.

Family Member	Alive (age)	Deceased age	No significant disease	Past condition	Current condition
Father					
Mother					
Paternal Grandfather					
Paternal Grandmother					
Maternal Grandfather					
Maternal Grandmother					
Son(s)					
Daughter(s)					
Brother(s)					
Sister(s)					

Social History: Mark ALL that apply.

Alcohol: do not drink alcohol social consumption only drink the following regularly (mark below)
 beer liquor wine quantity of _____ oz./glasses per day week month

Substance: never used illegal drugs has not used illegal drugs since _____.
 Never used IV drugs used illegal drugs for _____ (how long?)

Tobacco: Do not use tobacco do not smoke cigars, cigarettes, or pipe Live with a smoker Quit smoking
 Smoke: # _____ per Day Week Month Chew: # _____ cans per Day Week Month

Terms of Acceptance

In order to provide for the most effective environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimal health through chiropractic. To that end, we ask that you acknowledge the following points regarding chiropractic care and the services that are offered through this clinic:

- A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
- B. Chiropractic seeks to maximize the inherent healing powers of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structure and configurations that interfere with normal nerve processing.
- C. The chiropractic adjustment process involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day by doctors of chiropractic in the United States alone.
- D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
- E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
- F. **Appointment policy:** To provide the best possible care to all, we require 24 hours' notice for all rescheduling/cancellation requests. In the case of a cancellation/rescheduling request made less than this time frame or no-show of a scheduled appointment the account on file will be charged a fee of \$50. Also, late arrivals of more than 15 minutes will be charged a fee of \$50.
- G. I understand that it is my responsibility to inform my doctor if I ever have a change in health. I hereby authorize Rowe Family Chiropractic Center, P.A. to care for my diagnosed problem(s) as deemed appropriate using chiropractic care. And I give authority for these procedures to be performed.

By my signature below, I have read and fully understand the above statements. All questions regarding the doctor’s objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

Printed Patient Name

Date

Signature of Patient

WRITTEN CONSENT FOR A CHILD

NAME OF PATIENT WHO IS A MINOR/ CHILD _____

I (parent/legal guardian name) _____ request and authorize Dr. Nicholas Rowe and Dr. Keri Rowe and its personnel to deliver routine chiropractic care (including DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATIONS, RENDER CHIROPRACTIC CARE AND PERFORM CHIROPRACTIC ADJUSTMENTS) to my child listed above as may be deemed necessary or advisable in the diagnosis and treatment of the minor child. I am also aware that the adult presenting the child is responsible for payment of the patient portion at the time of service.

I have the legal right to preauthorize Rowe Family Chiropractic Center, P.A., and its personnel, to deliver routine chiropractic care to my child. I have read, understand, and give my consent as stipulated above. My signature means that I have read this form and/or have had it read to me and explained in the language that I can understand.

Printed name of Parent or Legal Guardian

Relationship to Minor

Signature of Parent or Legal Guardian

Date

X-RAY AUTHORIZATION

As your healthcare provider, we are legally responsible for your chiropractic records. We must retain a record of your x-rays in our files. **PLEASE NOTE:** X-rays are utilized in this office to help locate and analyze vertebral subluxations. These X-rays are not used to investigate medical pathology. The doctors of Rowe Family Chiropractic Center, P.A. do not diagnose or treat medical conditions. However, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice. It is understood and agreed that the amount paid for X-rays is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. By signing, you agree to the above terms and conditions. **FEMALE PATIENTS ONLY:** To the best of my knowledge, I **BELIEVE I AM NOT PREGNANT** at the time X-rays are taken at Rowe Family Chiropractic Center, P.A.

Printed Patient Name

Date

Signature of Patient

Age

Assignment of Benefits Agreement

I hereby certify that the insurance information that I have provided Rowe Family Chiropractic Center, P.A. is true and

accurate as of the date of service. I certify that benefits, to pay any-and-all medical claims, are available as of the date of this agreement. If authorization is needed to provide me with medical care, I certify that I have obtained said authorization or have instructed Rowe Family Chiropractic Center, P.A. to obtain authorization from my insurance company, in order to seek medical care from Rowe Family Chiropractic Center, P.A.

I understand that intentionally providing false insurance information may be considered as fraud. I am fully aware that having health insurance does not release me of my responsibility to ensure that my medical bill is paid in full. I also understand that my insurance company may not pay 100% of the amount of the medical claim and I may be responsible for any and all amounts not payable by my insurance company.

I hereby authorize Rowe Family Chiropractic Center, P.A. to submit claims, on my behalf, to the insurance company listed on the copy of the current insurance card I have provided, in good faith. I fully agree and understand that the submission of a claim does not release me of my responsibility to ensure that the claim is paid in full. I hereby instruct and direct my Insurance Company (listed on the copy of the current insurance card I have provided), to pay Rowe Family Chiropractic Center, P.A. 6271 Lake Osprey Dr. Lakewood Ranch, FL 34240. If my current policy prohibits direct payment to the provider of service, I hereby also instruct and direct said insurance company to make the check payable to me and mail it to: Rowe Family Chiropractic Center, P.A. where I will endorse the check and surrender payment for the professional or medical expense benefits allowable.

This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. Upon receipt of said payment, I authorize Rowe Family Chiropractic Center to deposit payments received on my account when made out to me. I authorize Rowe Family Chiropractic Center, P.A. to make deposit into its account on my behalf.

I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. A photocopy of this document shall be considered as effective and valid as the original.

Printed Patient Name

Date

Signature of Patient or Policy Holder (if not Patient)

Designation of Authorized Personal Representative

I authorize Rowe Family Chiropractic Center, P.A. to be my personal representative, which allows Rowe Family Chiropractic Center, P.A. to: (1) submit any-and-all requests for benefit information from my insurance company and to receive such information on my behalf, (2) submit any and all appeals when my insurance company denies me benefits to which I am entitled, and (3) initiate formal complaints to any State or Federal agency that has jurisdiction over my policy/benefits. I fully understand and agree that I am responsible for full payment of my accrued medical debt if my insurance company has refused to pay 100% of my benefits, within ninety (90) days of any-and-all appeals or requests for information. I also agree that any fines levied against my insurance company will be paid to Rowe Family Chiropractic Center, P.A. for acting as my personal representative.

A photocopy of this document shall be considered as effective and valid as the original.

Printed Patient Name

Date

Signature of Patient or Policy Holder (if not Patient)

Notice of Privacy Practices for Protected Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information. We must abide by the terms of this Notice while it is in effect. However, we reserve the right to change the terms of this Notice and to make the new notice provisions effective for all of the protected health information that we maintain. If we make a change in the terms of this Notice, we will notify you in writing and provide you with a paper copy of the new Notice, upon request.

Uses and Disclosures

There are a number of situations in which we may use or disclose to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure. We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment. *Example:* We may use your health information within our office to provide health care services to you or we may disclose your health information to another provider if it is necessary to refer you to them for services. Payment. *Example:* We may disclose your health information to a third party such as an insurance carrier, an HMO, a PPO, or your employer, in order to obtain payment for services provided to you.

Health Care Operations. *Example:* We may use your health information to conduct internal quality assessment and improvement activities and for business management and general administrative activities.

Appointment Reminders. *Example:* Your name, address and phone number and health care records may be used to contact you regarding appointment reminders (such as voicemail messages, postcards or letters), information about alternatives to your present care, or other health related information that may be of interest to you.

Protection of Reproductive Health Information: Your health information related to reproductive health is protected by federal law. We are committed to safeguarding this information and ensuring that it is used and disclosed only as permitted by law.

- Disclosure Prohibitions: We will not disclose your reproductive health information for purposes not authorized by law, including in response to certain legal requests unless they comply with strict federal requirements.
- Attestation Requirement: If we receive a request for your reproductive health information from law enforcement, oversight agencies, or other entities, we will require a signed attestation confirming that the request complies with all applicable federal and state laws protecting this type of information.
- Your Rights:
 - You have the right to access, inspect, and obtain copies of your reproductive health information.
 - You may request restrictions on certain uses and disclosures of your reproductive health information.
 - You may file a complaint with us or the Office for Civil Rights if you believe your privacy rights have been violated.

Substance Use Disorder (SUD) Records: Protected Health Information (PHI) related to Substance Use Disorder (SUD) treatment is subject to special protections under federal law (42 CFR Part 2) and HIPAA.

- Prohibited Disclosures: We will not disclose your SUD-related health information without your specific written consent, except as permitted by law. These disclosures include treatment, payment, and healthcare operations only when allowed under federal law.
- Single Consent: You may provide a single written consent allowing the use and disclosure of your SUD-related health information for treatment, payment, and healthcare operations across multiple providers or entities involved in your care.
- Revocation of Consent: You have the right to revoke your consent at any time, except to the extent that disclosures have already been made in reliance on it.
- Exceptions: We may disclose SUD-related information without your consent in specific circumstances, including medical emergencies, audits or evaluations, or when required by a court order

Commitment to Privacy: Our organization will take reasonable steps to ensure the confidentiality of reproductive health information and to address any questions or concerns about how it is used or disclosed. If you have any questions about this section or your rights, please contact our Privacy Officer at [Insert Contact Information].

There are certain circumstances under which we may use or disclose your health information without first obtaining your Acknowledgement or Authorization:

Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. You should be aware that we utilize an “open adjusting office setting” in which several people may be adjusted at the same time and in close proximity. We will try to speak quietly to you in a manner reasonably calculated to avoid disclosing your health information to others; however, complete privacy may not be possible in this setting. If you would prefer to be adjusted in privacy, please let us know and we will do our best to accommodate your wishes.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person’s involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

EXCEPT AS INDICATED ABOVE, YOUR HEALTH INFORMATION WILL NOT BE USED OR DISCLOSED TO ANY OTHER PERSON OR ENTITY WITHOUT YOUR SPECIFIC AUTHORIZATION, WHICH MAY BE REVOKED AT ANY TIME. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization.

Patient Rights

Right to Request Restrictions: You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction. Your request must be made in writing to our Privacy Official.

Right to Receive Confidential Communications: You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled. Your request to receive confidential communications must be made in writing to our Privacy Official.

Right to Inspect and/or Copy: You have the right to inspect, copy and request amendments to your health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information. Your request to inspect and/or copy your health information must be made in writing to our Privacy Official.

Right to Amend: You have the right to request that we amend certain health information for as long as that information remains in your record. Your request to amend your health information must be made in writing to our Privacy Official and you must provide a reason to support the requested amendment.

Right to Receive an Accounting.: You have the right to inspect, copy and request amendments to your health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information. Your request to receive an accounting must be made in writing to our Privacy Official.

Right to Receive Notice: You have the right to receive a paper copy of this Notice, upon request.

Complaints: You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint.

All questions concerning this Notice or requests made pursuant to it should be addressed to: Privacy Officer, Rowe Family Chiropractic Center, P.A.

I do hereby acknowledge receipt of a copy of the Notice of Privacy Practices, Policies, and Procedures.

Printed Patient Name	Patient Signature	Date
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Printed Name of Patient’s Representative	Signature of Patient’s Representative	Date
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Legal Authority of Patient’s Representative

Informed Consent for Chiropractic Care

We encourage and support a shared decision making process between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations.

Vertebral subluxation is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing. The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic

adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life. In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE Rowe Family Chiropractic Center, P.A., its doctor's and employees TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

Printed Patient Name Patient Signature Date

Parental Consent for a CHILD:

In addition, by signing below, I give permission for the above named MINOR patient to be managed by the doctor even when I am not present to observe such care.

Patient Name Patient Age Date of Birth

Printed name of Parent or Legal Guardian Relationship to Minor

Signature of Parent or Legal Guardian Date