Terms of Acceptance

When a member of Vital Chiropractic Center seeks chiropractic health care and we accept a member for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each member understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of hand delivered forces to facilitate the body's correction of vertebral subluxation. Our Chiropractic method of correction is by specific adjustments to the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra of the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advise, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only practice is to eliminate a major interference to the expression of the nerve impulse. Our only method is the specific adjusting to correct vertebral subluxations.

I, ______________________________ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept Chiropractic care on this basis.

Signature______________________________ Date______________

Children's Case History

Child's name:______________________________ Birthdate:______________

Sex:______________________________ Gender Identity: ______________________

Address:______________________________ City:______________ Zip:________

Parents' names:____

Parent's Phone:______________________________ Work#:______________________

Siblings and ages:____

____

____

Who referred you to our office?______________________________________

Reason for Consulting Our Office Today: ______________________________

Email Address: ____

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications: Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment , to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.

If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

____ (Patient Initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing. The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is______________________________.

The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is______________________________________.

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

CAUSE

The human body is designed to be healthy. The primary system in the body which coordinates health is the nervous system. The healthy function of every cell, every system, every organ is dependent upon the integrity of the nervous system. The bones of the skull and vertebrae of the spine house and protect the central nervous system.

From the birth process until the present, events have occurred in your child's life which may have caused interference and damage to this delicate system. Physical, emotional and chemical stresses common to our contemporary lifestyles can result in misalignment and damage to the spinal column. This interference is called the Vertebral Subluxation Complex.

This form will help reveal the causes of Vertebral Subluxation which interfere with the optimal function of your child's nervous system and therefore impair your child's inborn health and well-being.

Vertebral Subluxation Assessment

- Has your child been checked by a Doctor of Chiropractic?____________________
- Who?____________________ Were x-rays taken?____________________
- Who is your regular pediatrician?____________________

Experts around the world agree: the birth process as we know it may cause extensive neurological trauma, damage and even death to the infant.

- Did you have ultrasound during this pregnancy?____________________ Frequency____________________
- Place of birth: ☐ Home ☐ Birthing Center ☐ Hospital.
- Provider: ☐ Midwife ☐ OB-Gyn ☐ Other____________________
- Type of Birth: ☐ Vaginal ☐ C-section. Was anesthesia used?____________________ Type____________________
- Was labor induced?____________________ If yes, why?____________________
- What position did you deliver in: ☐ Squatting ☐ On Back
- Birth Trauma: ☐ Doctor assisted ☐ Twisting, Pulling ☐ Vacuum Extraction ☐ Forceps
- Newborn trauma (medical procedures and tests)____________________

Did you breast-feed your child? ☐ yes ☐ no. How long?____________________

Was your decision supported by your health care provider? ☐ yes ☐ no.

Repeated studies are now informing us breast-feeding develops strong and healthy immune, neurological and digestive systems.

According to the National Safety Council approx. 50% of infants have fallen onto their heads during their first years of life. Another study reveals 1/4 million children are injured in playgrounds annually. Can you recall any such jolts, falls or traumas to your child?____________________

Please Describe:____________________

____

____

Any fractures or dislocations?____________________

Which sports does your child play?

☐ Soccer ☐ Football ☐ Gymnastics ☐ Karate ☐ Hockey ☐ Lacrosse

☐ Basketball ☐ Dance ☐ Wrestling ☐ Baseball ☐ Other____________________

Other than the 5 hours per day spent sitting in the classroom, does your child spend additional prolonged time sitting?

☐ yes ☐ no. Is it in front of a computer or TV? ☐ yes ☐ no.

How would you rate your child's diet?____________________

Does your child consume artificial sweeteners?__________ Flouridated water?__________

Check any of the following conditions your child has suffered from:

☐ Colic ☐ Irregular ☐ Sleeping ☐ Patterns ☐ Night Terrors ☐ Seizures

☐ Tantrums ☐ Ear Infections ☐ Allergies ☐ Asthma ☐ Headaches ☐ Poor Digestion

☐ Repeated Infections or Colds ☐ Bed Wetting ☐ Learning Disorders ☐ Emotional Disorders

☐ ADD or ADHD ☐ Other____________________

How often has your child been treated with drugs?____________________

Were you informed of their adverse reactions? ☐ yes ☐ no

If it was an antibiotic, was your child cultured for its use?____________________

Is your child currently on any medications? (please list)____________________

Any surgeries?____________________

The child's immune system, like all other developing systems of the body is both intricate and delicate. It strives for a state of homeostasis and balance in the body. Long term, adverse effects from interfering with this process with artificial immunizations are just being uncovered. Were you adequately informed of the risks of vaccinating your child? Did your child experience any behavioral, emotional or physical changes within 3 months after any shots?__________

Describe____________________

Was it reported by you or your doctor?____________________

Correction

Today, we are becoming more aware, how current technological lifestyles and practices expose our children's nervous systems to continuous stresses. These result in Vertebral Subluxations.

Current scientific research is showing the direct relationship between the function of the nervous system and the immune system function. The integrity of the nerve system is therefore imperative to a healthy immune system in your growing child.

Today, your child has the opportunity to have a spinal analysis by a Doctor of Chiropractic, the only health care provider qualified to locate, analyze and correct the Vertebral Subluxation Complex. Correction of the Subluxation with the Chiropractic Adjustment is the beginning of greater health and well-being for your child.

Authorization for Care of a Minor

I hereby authorize Dr. ____ to administer care as deemed necessary to my son/daughter.

Signature ____ Date __________________

Witnessed ____ Date __________________

Authorization to Use Patient Records for Research

I hereby authorize Dr. ____ to utilize my child's records for research. Patient names are not shared for research papers.

Signature ____ Date __________________

Authorization to Take and Publish Photographs

I, ____________________________, authorize Dr. ____

or another person authorized by him/her to take and publish photographs of my child, ______________________, for clinical records. Such photographs may be used in publications for the purpose of scientific and /or clinical research, chiropractic education, and the promotion of chiropractic health care when the above named Doctor deems such publication will benefit these goals.

I also understand I will not be identified by name without additional authorization.

Signature ____ Date __________________

Witnessed ____ Date __________________

FORM-P-005

Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by **Vital Chiropractic** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Vital Chiropractic**.

I understand that diagnosis or treatment of me by **Vital Chiropractic** may be conditioned upon my consent as evidenced by my signature on this document.

I understand 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 health care operations of the practice. **Vital Chiropractic** is not required to agree to the restrictions that I may request. However, if **Vital Chiropractic** agrees to a restriction that I request, the restriction is binding on **Vital Chiropractic** and **Vital Chiropractic**.

I have the right to revoke this consent, in writing, at any time, except to the extent that **Vital Chiropractic** or **Vital Chiropractic** 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. This 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 understand I have a right to review **Vital Chiropractic**'s Notice of Privacy Practices prior to signing this document.

The **Vital Chiropractic**'s Notice of Privacy Practices has been made available to me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my care, payment of my bills or in the performance of health care operations of the **Vital Chiropractic**.

The Notice of Privacy Practices for **Vital Chiropractic** is also provided and displayed in the reception area along the north wall.

This Notice of Privacy Practices also describes my rights and the duties of **Vital Chiropractic** with respect to my protected health information.

Vital Chiropractic 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 and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

____

Signature of Patient or Personal Representative

____

Name of Patient or Personal Representative

____

Date

____

Description of Personal Representative's Authority

Financial Policies and Agreement

It is extremely important that we clarify our financial policies so there is no confusion about everyone's responsibilities and expectations when it comes to paying for care. Outlined below is our Financial Policies and Agreement.

THIRD PARTIES

If you have health insurance that we are IN-NETWORK with, were injured on the job, in an automobile accident or some other personal injury, you may have other options. In general, we expect payment of deductibles, co-payments and co-insurance at the time of each visit, or at the end of the week when multiple visits per week are occurring.

I (the client) am responsible for all co-payments, deductibles, and co-insurance as per the terms of my contract with my insurance carrier.

All co-payments must be paid at the time of service

I am responsible for obtaining any and all required referrals for service. I am responsible for all non-covered services. The office will do its best to inform me of any service that will not or may not be covered. However, I understand that benefits are not determined by my insurance carrier until after the claim is submitted; therefore, there is no guarantee of payment by my insurance carrier.

I am responsible for updating my health insurance information with the office any time the information changes, terminates, or new coverage begins. The office will submit my medical claims for me as per the terms of the contract with my insurance carrier. For insurances we are OUT OF NETWORK with we will not directly bill but we will supply our client with an itemized statement, or a "superbill", that they can directly submit to their insurance company.

The office is restricted to a "timely filing period." I understand that I must supply the office with my health insurance card in a timely fashion, so that the claim may be paid. Any claim unpaid because I did not supply the office with my health insurance information in a timely fashion is my responsibility and I agree to make payment

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY

I hereby authorize payment directly to the Provider. I understand that my insurance policy is a contract between myself and my insurance provider and that I am ultimately financially responsible for non-covered services. The Provider will file my insurance claim only as a courtesy.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the Provider to release any information required to process my claim.

Individual Consideration: If there is financial hardship associated with receiving care in our office, please understand that we have never refused any client due to their financial situation. We will however come to some agreement for payment of services that both parties can agree on.

BILLING

We have a payment at time of service policy however we understand that circumstances sometimes change. Outstanding balances will be billed monthly and considered past due 14 days after the invoice date. Balances beyond 45 days will be charged a billing fee of 5% per month, plus any legal or collection fees.

A check returned from our financial institution is subject to a returned check fee.

The current fee is $35.00 per return.

MISSED APPOINTMENTS

Vital Chiropractic, PLLC and Wellness Center is committed to providing all of our clients with exceptional care. We understand that situations arise in which you must cancel or reschedule your appointment.

We strive to help as many individuals and families to live their best life through wellness! When a client cancels or reschedules without giving enough notice, they prevent another client from being seen and reaching their wellness goals.

Please call us at 360-848-6755 by 1:00pm on the business day prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 1:00 PM on Friday. If prior notification is not given you may be charged $30 for the missed appointment.

AGREEMENT

This is the entire financial agreement between Vital Chiropractic, PLLC and the patient below. I have read this agreement, understand it and agree with its provisions.

____

Patient’s Name Printed

____

Patient Signature

____

Guardian Signature if applicable

____

Date Signed

You may revoke this authorization at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed. Your revocation request should be addressed to our office:

Vital Chiropractic, PLLC
600 N 4th Street
Mount Vernon, WA 98273

Submit Form