Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and the risks associated with care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted with be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure. As with all types of healthcare interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increasing symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect strokes, there is a rare but serious condition known as cervical arterial dissection that involves an abnormal change in the wall of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The occurs in 3-4 of every 100,00 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headaches. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its consent, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future conditions(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent/Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

Doctor Name: _____ Signature: _____ Date: _____

PATIENT VERIFICATION

IF YOU RECEIVE CHECKS FROM YOUR INSURANCE COMPANY

I am receiving health care services from Arizona Family Wellness ("The Provider"). As a condition of receiving these services and to induce The Provider to wait for payment from my insurance companies, I have assigned my right to receive benefit payments from my insurance directly to The Provider. This Assignment cannot be cancelled.

I understand that my insurance carrier may issue checks to The Provider, to myself, or to the primary policy holder. In the event I receive any check from my insurance carrier or from any insurance company or third party as a result of these services, I agree to deliver such checks to The Provider within 3 business days from the date of such receipt, and to endorse such checks to The Provider.

I understand that should I receive monies for such services which I do not deliver to The Provider, I may be additionally responsible for attorneys' fees and punitive damages.

Date: _____ _____

Patient Name (please print)

_____

Patient's Signature

Arizona Family Wellness
6033 W Bell Rd Suite H
Glendale AZ 85308

Dr Hannah Dvorak, D.C.
Phone: (602)-978-3321
Fax: (602)-978-5701

Medical Release Form

I, the undersigned, hereby authorize Arizona Family Wellness to release copies of medical records on:

Medical Information to be Released Form:

Patient Name: _____

Address: _____

Phone: _____

Date of Birth: _____

Primary Care Office Name: _____

Primary Care Address: _____

Primary Care Phone: _____

Medical Information Releasing To:

Company Name: **Arizona Family Wellness**

Address: **6033 W Bell Rd Suite H Glendale AZ 85308**

Phone: **(602)-978-3321**

I understand that by signing this medical release form, all of my records pertaining to this particular injury or situation, will be released to a third party to (1) further treat my condition, (2) for further review by the insurance company at the end of treatment, and/or (3) to refer to another physician/specialist.

Patient's Signature: _____ Date: _____

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health-related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply to all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices, or any aspect of our privacy activities you should direct your complaint to Dr. Hannah Dvorak.

If you would like further information about our privacy policies and practices, please contact: *Dr Hannah Dvorak at (602)-978-3321.*

This notice is effective as of the day of signature. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____ _____

Name (Please Print) Signature Date

If you are a minor or if you are being represented by another party:

_____ _____

Personal Representative Printed Personal Representative Signature Date

_____

Description of the authority to act on behalf of the patient.

ARIZONA Family Wellness

Name:_____ Address: _____

City: _____ State:_____ Zip: _____ Home phone#:_____

Cell#(For confirming appt. schedule):_____ Carrier: _____

E-mail Address (For confirming appointment schedule): _____

SSN: _____ Date of birth: _____ Age: _____ Height: _____ Weight: _____

☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced # of Children _____ Name of spouse (or parent) _____

Employer: _____ Address: _____

City:_____ State:_____ Zip: _____ Work phone#:_____ Occupation: _____

_____

What is the name of your family physician? _____ What city are they located in?_____

Have you ever had Chiropractic care before? _____ If yes, doctor name: _____ Date of last visit_____

If you are experiencing any pain (neck pain, mid back pain, low back pain, etc.), health problems, symptoms, and/or complaints, please list in order of severity:

1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____
4. _____ For how long? _____

Has the problem been getting ☐ worse or ☐ staying the same? Currently or in the past have you ever experienced any of these complaints while working? _____ If yes, please describe what activities at work may be causing you these complaints: _____ Are there any other activities, incidents, or events outside of work that may have caused these complaints? _____ If yes, please explain: _____

Have you at any time in the past ever suffered a work injury? _____ If yes, what is the date of injury? _____

Do you have an attorney representing you for this work injury? ☐ Yes ☐ No If yes, who is your attorney?_____

Have you been involved in an auto accident in the last 12 months? ☐ Yes ☐ No If yes, date of accident? _____

Do you have an attorney representing you for this auto accident? ☐ Yes ☐ No If yes, who is your attorney? _____

How many other passengers were in the car with you? _____

List other doctors consulted for these conditions: _____

If due to an auto accident, what is the name of your auto insurance company? _____

_____

Have you ever had any surgeries or hospitalizations? _____ If yes, please list: _____

Please list any current or past injuries and illnesses not listed above: _____

Please check all medications (over the counter and/or prescribed) you are currently taking: ☐ Aspirin/Tylenol ☐ Pain killers ☐ Muscle Relaxers ☐ Insulin ☐ Birth Control Pills ☐ Sleeping Pills ☐ Anti-Depressants ☐ Others _____

_____

Health Insurance Co. Name _____ Policy Holder's Name _____ Policy Number _____

The rating scale below is designed to measure the degree to which several aspects of your life are presently disrupted by your health condition (pain and/or symptoms you may be experiencing). In other words, we would like to know how much your health condition (pain and/or symptoms you may be experiencing) is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

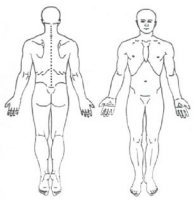
For each of the six categories of daily living listed, PLEASE INDICATE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVIES. 0 means no disability at all, and a score of 10 means that all of the activities in which you would normally be involved have been totally disrupted or prevented by your health condition (Pain and/or symptoms you may be experiencing).

0 1 2 3 4 5 6 7 8 9 10

Completely able to function Totally unable to function

1. FAMILY/HOME RESPONSIBILITIES: activities related to the home or family including chores and duties performed around the house (yard work, doing dishes, errands, favors for other family members, driving children to school, etc.) _____
2. RECREATION: hobbies, sports, and other similar leisure time activities _____
3. SOCIAL ACTIVITY: activities which involve participation with friends and acquaintances other than family members including parties, theater, concerts, dining out, and other social functions. _____
4. OCCUPATION: activities that are a part of or directly related to one's job including nonpaying jobs as well, such as that of a homemaker or of volunteer work _____
5. SELF CARE: activities which involve personal maintenance and independent daily living (taking a shower, driving, getting dressed, etc.) _____
6. LIFE SUPPORT ACTIVITY: basic life supporting behaviors such as eating, sleeping, and breathing. _____

If you are experiencing any health problems, please mark the exact location of your pain on the diagram below. Also describe the type of frequency of your pain. For example: dull, sharp, constant, off and on, when standing, sitting, walking, etc.



Method of payments for today's charges: ☐ CASH ☐ CHECK ☐CREDIT CARD ☐ _____

NOTICE: NOT ALL PATIENTS REQUIRE X-RAYS TO DETERMINE TYPE OF CARE AND LENGTH OF CARE. IF YOUR EXAMINATION WARRANTS X-RAYS ANALYSIS, THE FOLLOWING OFFICE POLICY PREVAILS:

1. All first visit charges are payable when services are rendered.
2. The fee paid for x-rays is for analysis only. We are required to maintain your original x-rays. Films may be loaned to another health provider with your prior authorization only.

Patient's Signature: _____ Date: _____