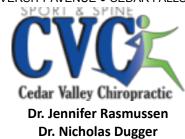
CEDAR VALLEY CHIROPRACTIC SPORT & SPINE

Patient Data	Date:					
First Name:	rst Name:Middle Initial: Last Name:					
Address:						
	State:					
Home Phone: ()	Work Pho	Work Phone:()				
Cell Phone: ()	Email:					
Date of Birth:	Sex: □Male □Female	Marital Status	: □Single □Married □Other			
Employment Status: □Emp	oloyed □ Student □Other/Retired Em	ployer Name:				
Emergency Contact						
Name:	Phone: ()	Relationship to y	/ou:			
insurance company and Co- unless you have made arrar <u>Students</u> If you are a student, are y	our parents paying for your bill?	e expected at the t	time services are rendered			
Address:	: City	State:	Zip Code			
Signature on File I authorize use of this form of authorize release of inform I authorize that I am response I authorize my doctor to act I authorize direct payment to	on all my insurance submissions. Pation to all my insurance companies Sible for my bill. as my agent in helping me obtain pa	yment from my ins				
Signature:	D:	ate:				
Did someone refer you to	our office? If so whom?					



Consent for Communication

Patients/Clients frequently request that we communicate with them by phone, voicemail, email or text. Cedar Valley Chiropractic Sport & Spine respects your right to confidential communications about your protected health information (PHI) as well as your right to direct how those communications occur. Since email and texting can be inherently insecure as a method of communication, we will only communicate with you by email or text with your written consent at the email address or phone number you provide to us below. Please be aware that if you have an email account through your employer, your employer may have access to your email.

When you consent to communicating with us by email or text you are consenting to email and texting communications that may not be encrypted. As well, voicemail or answering machine messages may be intercepted by others. Therefore, you are agreeing to accept the risk that your protected health information may be intercepted by persons not authorized to receive such information when you consent to communicating with us through phone, email or text. Cedar Valley Chiropractic Sport & Spine will not be responsible for any privacy or security breaches that may occur through voicemail, email or text communications that you have consented to.

You may choose to limit the type of email or text communication you have with us if you wish to limit your risk of exposing your protected health information to unauthorized persons. Please indicate below what types of correspondence you consent to

Patient/Authorized Representative/Guardian Signature	Date
Patient Name:	Date
NOTICE OF PRIVACY PRACTICES SUME This summary discloses how health information about you may be used. A full notice provided to you. Cedar Valley Chiropractic uses health information about you for the administrative purposes, and to evaluate the quality of care that you receive. Cedar information to others unless you tell us to do so, or unless the law authorizes or remay use your information to provide appointment reminders, information about treatissues. Cedar Valley Chiropractic may disclose your information for public health a governmental functions in order to comply with workers compensation laws and ot restriction of your health records, report, and retain a copy of your health records, alternative means at alternative locations, revoke your authorization and request a complain to the Privacy Officer, Dr. Jennifer Rasmussen, Dr. Nicholas Dugger, and Services if you believe your privacy rights have been violated. You will not be retail Valley Chiropractic must maintain the privacy of protected health information, proviprivacy practices with respect to your health information, abide by the terms of the the requested restriction on how your information is used or disclosed, accommod communicate with health information by alternative means or by alternative location use or disclose your health information for reasons other than those listed above a Notice of Privacy Practices is first in effect on this date of April 14, 2003. If you have any questions or complaints, please contact Dr. Jennifer Rasmussen of the province o	reatment, to obtain payment for treatment, for ar Valley Chiropractic will not disclose your quires us to do so. Cedar Valley Chiropractic atment alternatives or other health-related activities, health and safety, and/or ther regulations. You have a right to request request communication of your information by an accounting of your health records. You may do to the Department of Health and Human liated against for filing a complaint. Cedar lide you with notice of its legal duties and a notice, notify you if it was unable to agree to ate reasonable requests you may make to one and obtain your written authorization to and permitted under law. This Summary of the
Phone number you are consenting to communicate through:	
E-mail address you are consenting to communicate through:	
I consent to receiving communications via email and text including, but n medical condition, advice from my healthcare providers, the scheduling of appet that do not reveal my protected health information.	
I do not consent to any email or texting communication.	
receive by email or text.	

by

CEDAR VALLEY CHIROPRACTIC ● 5529 UNIVERSITY AVENUE ● CEDAR FALLS, IA 50613 ● (319) 268-9009 ● www.cvchiro.com



Dr. Nicholas Dugger

						
To the patient: 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 most frequent treatment I use as a Doctor of Chi may use my hands, the table or a small mechanical instrum oints. That may cause an audible "pop" or "click" much like t may feel a sense of movement. You may not always hear the	he noise heard when you crack your knuckles. You					
Other treatments Additional treatments may include: stretching, soft tis such as ice, heat, electrical muscle stimulation, traction, and	sue techniques that are similar to massage, modalities lexercise.					
Analysis/Examination/Treatment As a part of your visit you are consenting to the follow any procedures that you may have questions about.	wing procedures as the Dr. deems necessary. Check					
spinal manipulative therapy palpation	vital signs					
range of motion testing orthopedic testing	neurological testing					
muscle strength testing postural analysis	radiology testing					
electrical muscle stimulation traction	hot/cold					

PATIENT NAME:

rehabilitative exercise

other

The material risks in the chiropractic adjustment.

soft tissue therapy –manual or instrument assisted

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, and rib strains and separations. Some types of manipulations 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 will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during your examinations to screen for contraindications to care such as previous stroke or osteoporosis; however, if you have a condition or develop a condition that would otherwise not come to my attention, it is your responsibility to inform me.



Probability of risks occurring

Fractures are rare occurrences and generally result from some unknown underlying weakness of the bone. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare. The most common side effect is stiffness or soreness following treatment much like soreness after a deep tissue massage.

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, physical therapy, Rx drugs such as NSAIDS, muscle relaxers, and pain-killers
- o Possible surgical intervention (in some cases)

Risks and dangers of remaining untreated or not following through with the Dr.'s recommendations

Remaining untreated may allow the formation of adhesions and scar tissue and reduced 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 treatment is postponed. Not performing your home care plan such as ice, rehabilitation exercise, or activity modifications that the Dr. prescribes can lead to recurring episodes of symptoms that may lead to worsening of the condition and/or chronicity.

DO NOT SIGN UNTIL YOU HAVE READ AND FULLY UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BOX AND SIGN BELOW.

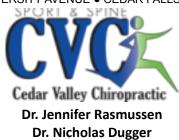
I have read [] or have had read to me [] the above explanation of the chiropractic adjustment and related treatment. I have discussed any questions with Dr. Rasmussen, Dr. Dugger, or their staff and have had my questions answered to my satisfaction. By signing below I state that I understand any risks, have weighed the risks involved and have decided that it is in my best interest to undergo the treatment recommended. Having been informed I voluntarily give my consent to the treatment.

Name:	Dr. Jennifer Rasmussen / Dr. Nicholas Dugger
Signature:	Signature:
Date:	Date:



	v n			

Have you ever been diagnosed with/currently have any of the following conditions/symptoms?						
(Check Y or N)						
Yes	No	Yes	No			
	Unexpected Weight Loss or Gain	_	Skin rash/Eczema/Psoriasis			
_	Blurred/Double vision	_	Dizziness/Vertigo/Ringing in ears			
_	Headache/Migraines	_	Depression/Anxiety/Unusually High Stress			
	Chest pain/Shortness of breath		Easy bruising/Blood clots			
	Unexplained Nausea/Vomiting	_	Unexplained Fever or Chill			
_	Difficulty or Pain With Urination/Bowel Movements	_				
_	Joint pains		Numbness/Tingling/Weakness in Arms or Legs			
	Hypertension	_	Immune Deficiency/Autoimmune Disorder			
_	Coronary Artery Disease	_	Recurrent Ear Infections/Ear Trouble			
_	Arthritis	_	Colitis/Diverticulitis/Celiacs			
_	Diabetes	_	Diarrhea/Constipation			
_	Cancer/Tumor		Stomach Pain/Ulcers/Heartburn/Acid Reflux			
_	Heart Attack/Congestive Heart Failure	_	Painful Urination/Recurrent Urinary Tract Infections			
_		_				
_	Aneurysm/Arterial/Vascular Condition/	_	Seizures/Tremors			
	Poor Circulation		No contract of the state of Access and the Management New York			
_	Asthma/Emphysema/Obstructive Lung Disorder	_	Numbness/Tingling/Arm or Leg Weakness Not From			
	C. I last C. I late		Pain			
_	Stroke/Mini-Stroke/TIA		Difficulty WIth Balance			
_	Back or Neck Pain		Pain in Arm, Leg, Hand, or Foot			
_	Thyroid Condition	_	Menopause or Menstrual Problems			
_	Osteoporosis/Osteopenia		Previous Joint Injury			
Is th	ere anything else you have, or have had, not included he	ere?				
FΑI	MILY HISTORY					
Has	anyone in your immediate family ever had the followir	ng?				
	Cancer		Diabetes			
	Stroke		Bleeding Tendency			
	Hypertension/Heart Disease		Other:			
PRE	SCRIPTION MEDICATIONS/OVER THE COUNTER SUPPLE	ME	NTS/ALLERGIES			
PAS	r Surgical History					
Do y	ou exercise regularly? Y N					
Have you taken any prescription steroids (cortisone, inhaler, or oral? Y N						
Do y	ou use Tobacco products currently? Y N		In the past? Y N			
•	•		•			
	CEDAD VALLEY CHIDODDACTIC . 5520 LINIVEDSITY AVE	NII IE	CEDAD EALLS IA 50613 (210) 269 0000 a variative overhire com			



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