**Westside Chiropractic of Tolland, LLC**
68 Hartford Turnpike Tolland, Connecticut 06084
Phone: 860-875-0029 Fax: 860-875-3445

## PATIENT INFORMATION

First Name_____ Last Name_____ Date of Birth_____
Street Address _____ Occupation _____
City _____State _____ Zip _____ email _____
Social Security # _____ Height _____ Weight _____ Sex M F Age _____
Home Phone _____Cell Phone _____Work Phone_____
Employer _____ Address _____
Marital Status S M D W P
Spouse's Name _____Cell Phone _____
Spouse's Employer _____Work Phone _____
Referred by _____

### EMERGENCY

In case of emergency, call
Name _____
Relationship _____
Home Phone _____
Work Phone _____

### ACCIDENT INFORMATION

Is condition due to an accident? Y N
Date of injury _____
Type: Auto Work Comp. PI
To whom did you make a report?
Work Supervisor _____
Police Report _____
Auto Insurance _____
Name of Attorney _____
Address _____
Phone _____

### INSURANCE

Who is responsible for this account? _____
Relationship to patient? _____
Primary Insurance _____
Secondary Insurance _____

### Assignment and Release

*I certify that I and/or my dependent(s) have insurance coverage with _____ and assign directly to Westside Chiropractic of Tolland all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.*
*The above-named doctor may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services. This consent will end when my current treatment plan is completed or one year from the date signed below.*

Patient Signature _____
Print Name _____
Relationship to Patient _____
Date _____

# Informed Consent to Chiropractic Treatment & Financial Policy

Chiropractic care is a system of health care delivery. As with any health care discipline, we cannot promise a cure for any symptom, disease or condition as a result of treatment. We will promise to give you our best to achieve good health and well-being the natural way.

The doctor will primarily provide chiropractic adjustments or manipulation during your course of treatment. This is done with the use of his/her hands and/or a mechanical device upon your body in order to move your joints in certain directions. This procedure may cause a "pop" or "click" to be heard from the area treated and should not be a cause for alarm. There are some material risks involved in these procedures which include:

1) Pain: Treatment may result in temporary increased soreness in the area treated
2) Rib fractures: These are rare and may occur in patients with osteoporosis or weakened bones. Evidence of osteoporosis or weakened bones may be noted on x-ray. If detected, treatment is modified to assure a gentle and effective adjustment is provided. Gentle treatment is applied to all patients. Specialized care is provided to young, frail and elderly individuals
3) Disc injury: Chiropractic treatment is appropriate for many types of spinal related conditions, including disc conditions. Occasionally, treatment may aggravate a problem if the disc is in a severely weakened state. This occurs so rarely that statistics to quantify the probability are unavailable, but estimates place the risk of serious injury at one per 100 million spinal manipulations.
4) Stroke: the incidence of stroke in the general population is 2 per 1000 people. Manipulation of the neck has been implicated as a cause of stroke in the past. Upon review of the literature and data, the incidence is one per five million manipulations. In comparison, the risk of death from taking non-steroidal anti-inflammatory drugs (aspirin, ibuprofen, naproxen, motrin, etc) is 4 per 100,000 patients. The risk of serious complications or death from spinal surgery is 11.25 per 1000 patients. The risk of chiropractic treatment is far less than the risk of medical and surgical treatment. Even though the risk of injury is very low, we include procedures and tests that may help us reduce the potential for stroke or other complications.

I (we) _____ hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures on me or on _____, by Westside Chiropractic of Tolland, LLC and /or other licensed doctors of chiropractic or other health care providers who may be employed by or engaged in practice of their respective discipline in the office of Westside Chiropractic of Tolland, LLC.

I have had an opportunity to discuss with the doctor, or other clinic personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that the practice of neither chiropractic nor medicine is an exact science and that my care may involve the asking of judgments based upon the facts known to the doctor at the time; that it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications; that an undesirable result does not necessarily indicate an error in judgment.

I have read or have had read to me the above Consent. I have also had an opportunity to ask questions about its content, and by signing below, agree to the named procedures.

_____/_____ _____/_____ _____

Patient's Name | Patient's Signature | Patient/Guardian Name | Signature | Date

## ASSIGNMENT, AUTHORIZATION, POWER OF ATTORNEY & AGREEMENT

Notice: This office is willing to wait for payment of services (supplies, equipment and missed appointment charges are excluded) when you (patient or guardian of the patient) agree to the following conditions

I agree to provide the office with information regarding my source of payment, to assist in any way I can, and:

1. I understand that if there is no third party reimbursement available, all fees are due when service is rendered unless other arrangements are made in advance of service.
2. I hereby assign to this office my rights to receive payments from negligent or other parties. Payments should be payable to: WESTSIDE CHIROPRACTIC OF TOLLAND, 68 HARTFORD TURNPIKE TOLLAND, CT 06084.
If my policy prohibits assignments then checks should be made payable to me and sent to the above address.
3. I understand that if this office receives more than their fees, the office will pay or credit balance to the PATIENT.
4. I authorize the release of information (with valid release of records) to any third party to assist in the payment of the claim.
5. I fully understand and agree that insurance policies are arrangements between an insurance carrier and me and/or the doctor and insurance company. I will be responsible for any expense not paid by insurance and determined to by my responsibility.
6. A photocopy of this form shall be as valid as the original.
7. I shall make payment immediately for any missed appointment when the office is not provided notice within 24 hours.

PATIENT NAME_____SIGNATURE_____ DATE_____

RESPONSIBLE PARTY NAME_____ SIGNATURE_____

**HEALTH INFORMATION SURVEY**

First Name _____ Last Name _____ Date _____

Reason for Visit _____

How often do you have this pain?

____ Constant 76-100% ____ Frequently 51-75%

____ Occasionally 26-50 ____ Intermittent 1-25%

Type of Pain:

____ Sharp ____ Dull ___ Diffuse ____ Achy____ Burning

____ Shooting ____ Stiff _____ Numb ___ Tingly _____

Has it changed over time?

_____ Getting worse ____ Not changing _____ Getting Better

Rate your pain on a scale from 1 (least pain) to 10 (severe pain)

1 2 3 4 5 6 7 8 9 10

Does it interfere with your work? ___ No ____ Slightly

_____ Moderately _____ Substantially _____ Extremely

Have you seen any other doctors or therapists

Name _____

How long ago did the problem begin? _____

What aggravates the problem? _____

(i. e. bending, reaching, driving, sitting, standing, sleeping, working)

How would you rate your overall health?

_____ Excellent _____ Very Good ____ Good _____ Fair _____ Poor

How much regular exercise or sports do you perform?

_____ Strenuous ____ Moderate ____ Light _____ None

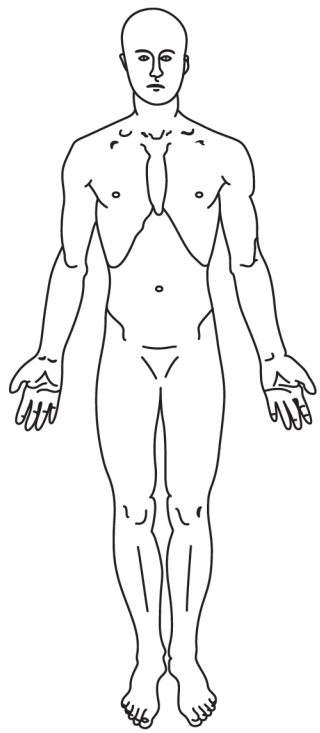
What kind of exercise or sports? _____

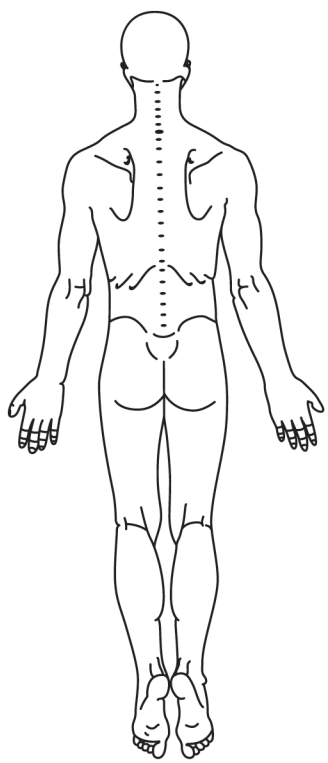
Have you ever seen a chiropractor before? When? _____

Name _____

Any past trauma or accidents? _____

_____





Please indicate on the body diagram where your pain is located at the present time.

## HEALTH HISTORY

Place a mark on "Past" or "Present" to indicate if you have had any of the following:

| Past | Present | | Past | Present | | Past | Present | |
|---|---|---|---|---|---|---|---|---|
| ___ | ___ | Headache | ___ | ___ | Chronic Sinusitis | ___ | ___ | Visual Disturbances |
| ___ | ___ | Neck Pain | ___ | ___ | High Blood Pressure | ___ | ___ | Dizziness |
| ___ | ___ | Upper back Pain | ___ | ___ | Heart attack | ___ | ___ | Diabetes |
| ___ | ___ | Mid back Pain | ___ | ___ | Chest pain | ___ | ___ | Excessive Thirst |
| ___ | ___ | Low Back Pain | ___ | ___ | Stroke | ___ | ___ | Frequent Urination |
| ___ | ___ | Shoulder Pain | ___ | ___ | Angina | ___ | ___ | Smoking/Tobacco use |
| ___ | ___ | Elbow/Arm Pain | ___ | ___ | Kidney Stones | ___ | ___ | Allergies |
| ___ | ___ | Wrist Pain | ___ | ___ | Kidney disorders | ___ | ___ | Depression |
| ___ | ___ | Hand Pain | ___ | ___ | Bladder infections | ___ | ___ | Systematic Lupus |
| ___ | ___ | Hip Pain | ___ | ___ | Painful urination | ___ | ___ | Epilepsy |
| ___ | ___ | Upper Leg Pain | ___ | ___ | Loss of bladder control | ___ | ___ | Dermatitis/Eczema |
| ___ | ___ | Knee Pain | ___ | ___ | Prostate problems | ___ | ___ | HIV/AIDS |
| ___ | ___ | Ankle/Foot Pain | ___ | ___ | Abnormal weight gain | ___ | ___ | Bone fractures |
| ___ | ___ | Jaw Pain | ___ | ___ | Loss of appetite | ___ | ___ | Osteoporosis |
| ___ | ___ | Joint Pain/Stiffness | ___ | ___ | Abdominal pain | ___ | ___ | Parkinson's disease |
| ___ | ___ | Arthritis | ___ | ___ | Ulcer | ___ | ___ | Thyroid Problems |
| ___ | ___ | Rheumatoid Arthritis | ___ | ___ | Hepatitis | ___ | ___ | Blood Clots |
| ___ | ___ | Cancer | ___ | ___ | Liver/gall bladder disorder | ___ | ___ | High Cholesterol |
| ___ | ___ | Tumor | ___ | ___ | General fatigue | ___ | ___ | Anxiety |
| ___ | ___ | Asthma | ___ | ___ | Muscular incoordination | | | |

Are you pregnant N Y Due Date_____

| Injuries/Surgeries you have had | Description | Date |
|---|---|---|
| Falls | _____ | _____ |
| Head Injuries | _____ | _____ |
| Broken Bones | _____ | _____ |
| Dislocations | _____ | _____ |
| Surgeries | _____ | _____ |
| Hospitalizations | _____ | _____ |
| Medications | _____ | |

Westside Chiropractic of Tolland and members of the practice staff may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine or with family member. By signing this form, you are giving us authorization to contact you with these reminders and information.

You can restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time, however, your revocation must be in writing and mailed to us at our office address. In addition, if you were required to give your authorization as condition of obtaining insurance, the insurance company may have right to your health information if they decide to contest any of your claims.

Information that we disclose based on the authorization you give us may be subject to re-disclosure by anyone who has access to the protected information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or methods we use to obtain reimbursement for your care.

This office may periodically videotape certain doctor/patient communications. These recordings are used for training purposes. By signing this form, you are giving us permission to periodically videotape communications you have with the doctor. You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives or other health related information at any time.

This notice is effective as of 11/1/2011. This authorization will expire seven years after the date in which you last received services from us.

I authorize you to disclose my health information in the manner described above. I also understand that I may receive a copy of this form if needed.

Signature_____Date_____

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## CONSENT TO PARTICIPATE IN TELEMEDICINE CONSULTATION

_____ (hereinafter "I") seek the telemedicine consultation of Westside Chiropractic of Tolland, LLC. I am executing this Consent to Participate in Telemedicine Consultation (**"Telemedicine Consent"**) to verify and confirm my discussion with Dr. Erin Shephard, a licensed Chiropractic Physician (**"Provider"**) regarding the risks, benefits, and alternatives to the telehealth consultation services through Practice. I am seeking the telemedicine consultation services of Practice for my own purposes and not on behalf of any third party. I understand that I am a participant in the decision-making process and I am free to decline services or treatments at any time. I retain the option to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled. I acknowledge that Provider may, in his or her sole discretion, determine whether the nature of my consultation is inappropriate for telemedicine, and may require me to come in for an in-person consultation. I agree to bring to the attention of Practice, if, at any time, I have any lack of understanding of such risks, benefits and alternatives, and inquire of Provider for further explanation until I have a full understanding before giving consent to any treatment or services.

1. **Purpose.** The purpose of this form is to obtain your consent for the use of telemedicine consultations with Provider. The purpose of the use of telemedicine consultations is to assist in the care and services provided by Practice and ultimately to assist in

2. **Nature of Telemedicine Consultation**. Telemedicine involves the use of audio, video or other electronic communications to interact with you, consult with your healthcare provider and/or review your medical information for the purpose of diagnosis, therapy, follow-up and/or educational purposes. During your telemedicine consultation, details of your medical history and personal history information may be discussed with other health professionals through the use of interactive video, audio and telecommunications technology. Additionally, a physical examination of you may take place and video, audio, and/or photo recordings may be taken.

3. **Risks, Benefits and Alternatives.** The benefits of telemedicine include having access to medical specialists and additional medical information and education without having to travel outside of your local health care community. Additional benefits are that patients may be diagnosed and treated earlier which can contribute to improved outcomes and less costly treatments. Potential risks of telemedicine include that because of your specific medical condition, or due to technical problems, a face-to-face consultation still may be necessary after the telemedicine appointment.

Practice has taken the following steps to ensure the privacy of the telemedicine consultation:

- We use only HIPAA compliant software through our Electronic Medical Record (EMR) software teleconferencing software, and other electronic service providers;
- We use password protected screensavers and data files; and

- We use other reliable authentication techniques and safeguards, both electronically and physically, to reduce the likelihood of patient data or privacy breaches.

In rare instances, technology failure may lead to the loss of information provided through telemedicine consultations. Additionally, in rare instances, security protocols could fail causing a breach of patient privacy. In rare cases, a lack of access to complete and/or accurate medical records or information may result in adverse drug reactions, allergic reactions, or other judgment errors. You agree to hold Provider and Practice harmless from any such information loss, and any resulting judgments or decisions, due to technological failures outside of their agency or control. The quality of transmitted data may also affect the quality of the services provided via the telemedicine consultation. The alternative to telemedicine consultation is a face-to-face visit with a physician.

4. **Medical Information and Records.** All laws concerning patient access to medical records and copies of medical records apply to telemedicine. Dissemination of any patient identifiable images or information from the telemedicine consultation shall not occur without your consent.

5. **Confidentiality.** All existing confidentiality protections under federal and state law apply to information used or disclosed during your telemedicine consultation. However, there are both mandatory and permissive exceptions to confidentiality, which may allow or require disclosure of information used or disclosed during the telemedicine consultation. You will be informed of any parties who will be present from the Practice during your telehealth consultation, and will have the opportunity to exclude anyone from attending the consultation.

6. **Rights.** You may withhold or withdraw your consent to a telemedicine consultation at any time before and/or during the consultation without affecting your right to future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled. You have the right to be informed of and object to videotaping or other recording of the telehealth consultation.

By signing below, I acknowledge and certify that:

- I understand that I may expect anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
- I have had opportunities to ask questions and have had them answered to my satisfaction.
- I have read and fully understand the foregoing Telemedicine Consent, and I have all of the knowledge I currently desire.
- I agree and accept all of the terms above. I am legally competent and have sufficient knowledge to give voluntary and informed consent.

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**PATIENT INFORMATION**

First Name_____ Last Name_____ Date of Birth_____

Street Address _____ Occupation _____

City _____State _____ Zip _____ email _____

Social Security # _____ Height _____ Weight _____ Sex M F Age _____

Home Phone _____Cell Phone _____Work Phone_____

Employer _____ Address _____

Marital Status S M D W P

Spouse's Name _____Cell Phone _____

Spouse's Employer _____Work Phone _____

Referred by _____

***I look forward in assisting you in achieving your current health goals and to guiding you in maintaining wellness throughout your life.***

**POLICIES AND PROCEDURES**

**NEW PATIENTS — HOW TO BOOK YOUR FUNCTIONAL MEDICINE APPOINTMENT**

1. Book your 15 minute complimentary phone call with Dr Shepherd under the Functional Medicine tab. Dr Shepherd will call you at your scheduled time.

2. INITIAL CONSULTATION: Schedule an initial telemedicine appointment under the Schedule your Functional Medicine appointment tab on our website westsidechiropracticoftolland.com. Please leave the best phone number to contact you for this telemedicine appointment. Fill out new patient paperwork and email it to Erin@westsidechiropracticoftolland.com. This is a HIPPA compliant email and your information will be confidential. You can also drop off or mail your paperwork to Westside Chiropractic of Tolland, 68 Hartford Turnpike, Tolland, CT 06084. During your first consultation we will review all of your New Patient Paperwork and determine appropriate lab tests to order to address your specific health concerns. Please leave the best number to reach you for your consultation.

PAYMENTS:

1.Payments are due at the time of booking an appointment but are 100% refundable if cancelled 24 hours ahead of scheduled appointment.

2. Rates are as follows: 60 Minute Consult-$289; 45 minute consult-$225; 30 minute consult-$150; 20 minute consult-$100

3. Methods of payment accepted are Visa, Mastercard or American Express.

NOTE: Do not sign this form unless you have read it and feel that you understand it. Ask any questions you might have before signing this form. Do not sign this form if you have taken medications which may impair your mental abilities or if you feel rushed or under pressure.

**PATIENT**

**SIGNATURE:** _____

**PRINT NAME:** _____

**TITLE (if legal representative or guardian):** _____

**DATE:** _____

I have explained this Informed Consent and answered all questions in layman's terms, and informed the patient of the available alternatives and of the potential risks. To the best of my knowledge, the patient has been adequately informed, comprehends the information, and has consented.

**PRACTICE**

**SIGNATURE:** _____

**PRINT NAME:** _____

**DATE:** _____

I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment. I authorize the release of my medical information to you. All information is confidential.

**IMPORTANT NOTES:** It is required that you have your own primary care physician. Dr. Shepard does not provide acute care services but will work with you on preventative, nutritional and functional medicine to help address the root cause of chronic health problems. We do not service medical emergencies. If you have a medical emergency, you must contact your primary care physician or dial 911.

I _____ have read and understood the Policies and Procedure.
(please print name)

Date _____

Signature _____