Patient Information and Consent

On Site Health Care Services, LLC

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The following patient information and consent will take approximately 30 minutes to complete. This paperwork requests a detailed personal and family medical history, as well as a detailed current medical profile. This detailed summary will allow On Site Health Care Services to best serve you in your health goals. Please be as detailed as possible. This paperwork must be completed prior to any appointments, analysis or care plan recommendations. If you have any questions in completing this paperwork, please contact On Site Health Care Services.

Patient Information

Name (First, Middle, Last)	**Birthdate**	**Age**	**Social Security #**	**Sex** ☐ **M** ☐ **F**

Address	Apt. #	City	State	Zip

Email Address

Cell Phone	Home Phone

Employer (or Parent's Employer if minor)	Occupation

Parent/Guardian Name (if minor)	Parent/Guardian Phone

Marital Status
- ☐ Married
- ☐ Single
- ☐ Widowed ☐ Divorced

Race
- ☐ White or Caucasian ☐ Black or African American
- ☐ American Indian/Alaska Native
- ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

Name of Spouse/Partner	**How Many Children?** Child 1 Age: ____ Child 2 Age:____ Child 3 Age: ____ Child 4 Age:____

Emergency Contact

Name (First, Middle, Last)	Relationship	Cell Phone	Home Phone

Address	City	State	Zip	Email Address

By signing below, I affirm the information provided above is correct.

Print Patient Name:____

Print Parent/Guardian Name (if applicable):____

Patient (Parent/Guardian Signature):_____________________________________ Date:_____________

Newsletter Communications

At On Site Health Care Services, we believe in educating our patients on a variety of subjects relating to a health and wellness lifestyle. To help achieve this goal, we send out electronic newsletters and communications to our patients via e-mail. These e-newsletters are intended strictly as informational and are not meant to intrude upon your privacy or to create e-mail spam. Please be assured that your e-mail address will be kept strictly confidential. If you would like to receive these e-newsletters, please indicate so below.

☐ Yes, I would like to receive the OSHC e-newsletters. ☐ No, please do not send these e-newsletters.

Past and Current Medical History

MAKE AN (X) BY ANY OF THESE CONDITIONS YOU MAY HAVE HAD OR CURRENTLY HAVE.
Include onset date (MM/YY).

- ☐ Heart Disease: ___________
- ☐ High Cholesterol: ___________
- ☐ Heart Attack: ___________
- ☐ Kidney, Bladder, Prostate Disease: ___________
- ☐ High Blood Pressure: ___________
- ☐ Blood Clots: ___________
- ☐ Bleeding Tendency: ___________
- ☐ Liver Disease: ___________
- ☐ Lung Disease: ___________
- ☐ Bowel Disease: ___________
- ☐ Diabetes: ___________
- ☐ Hypoglycemia (Low Glucose): ___________
- ☐ Thyroid Disease: ___________
- ☐ Stomach Disease: ___________
- ☐ Anemia Or Other Blood Disease: ___________
- ☐ Stroke: ___________
- ☐ Cancer (Past Or Present):________ What Type:___________
- ☐ Seizures: ___________
- ☐ Nerve Impairment: ___________
- ☐ Cervical Spine Disorder: ___________
- ☐ Lumbar Spine Disorder: ___________
- ☐ Severe Headaches: ___________
- ☐ Tuberculosis/Tb: ___________
- ☐ Muscle Disease: ___________
- ☐ Depression: ___________
- ☐ Anxiety: ___________
- ☐ Traumatic Brain Injury: ___________
- ☐ Concussion: ___________
- ☐ Insomnia: ___________
- ☐ Asthma: ___________
- ☐ Joint Replacement: ___________
- ☐ Arthritis: ___________
- ☐ Restless Legs: ___________
- ☐ Sexual Transmitted Disease: ___________

Past and Current Medical History

Please provide a detailed medical history including current and past diagnoses and any minor or major traumas, diseases, surgeries that you did not indicate above. Include approximate dates and length of health condition.

Previous Solutions/Therapies

Please provide a detailed summary of the previous therapies and solutions you have tried in the past to target your health concerns and conditions.

Family History

Please list family medical history for each family member and reason for death (if applicable).

Mother: Date of Birth:___________ Year of Death (if applicable):________

Reason for Death (if applicable):

Father: Date of Birth:___________ Year of Death (if applicable):________

Reason for Death (if applicable):

Sibling 1: Date of Birth:___________ Year of Death (if applicable):________

Reason for Death (if applicable):

Sibling 2: Date of Birth:___________ Year of Death (if applicable):________

Reason for Death (if applicable):

Grandmother (Maternal): Date of Birth:___________ Year of Death (if applicable):________

Reason for Death (if applicable):

Grandfather (Maternal): Date of Birth:___________ Year of Death (if applicable):________

Reason for Death (if applicable):

Grandmother (Paternal): Date of Birth:___________ Year of Death (if applicable):________

Reason for Death (if applicable):

Grandfather (Paternal): Date of Birth:___________ Year of Death (if applicable):________

Reason for Death (if applicable):

Prescriptions/Supplements/Therapies

Please list all current medications, supplements, or other therapies you are currently using for your health.

Personal Habits

Do you **currently** drink alcoholic beverages? ☐ Yes ☐ No If yes, ________ drinks per ☐ Day ☐ Week ☐ Month

If you do not currently, but previously drank alcoholic beverages, when did you stop (MM/YY)?________________

Do you **currently** smoke or chew tobacco? ☐ Yes ☐ No If yes, ________ times per day, ________ years of use

If you do not currently, but previously used tobacco, when did you stop (MM/YY)?________________

Do you **currently** use an e-cigarette? ☐ Yes ☐ No If yes, ________ times per day, ________ years of use

If you do not currently, but previously used e-cigarettes, when did you stop (MM/YY)?________________

Do you **currently** use recreational or medical marijuana? ☐ Yes ☐ No If yes, _____ times per day, ___ years of use

If you do not currently, but previously used marijuana, when did you stop (MM/YY)?________________

Do you **currently** use any other recreational drugs? ☐ Yes ☐ No If yes, _____ times per day, ___ years of use

If you do not currently, but previously used recreational drugs, when did you stop (MM/YY)?________________

Have you ever been addicted to prescription, non-prescription or recreational drugs? ☐ Yes ☐ No

If yes, which drugs and how long?____

Do you physically work out for fitness? ☐ Yes ☐ No

If yes,
How many times per week do you work out at a moderate level? _________ How long is each session?___________

What type of activities do you prefer? ____

On average, how many hours per week do you spend watching TV, Movies, Video Games, etc.? ___________

On average, how many hours per week do you spend working at a computer/laptop? _____________

On average, how many hours of restful sleep do you receive each night? ____________

What time do you normally wake up each morning?______ What time do you normally go to bed each night?_______

Are you currently following any type of diet or meal plan? ☐ Yes ☐ No

If yes, what type of diet or meal plan are you following?

Health Goals/Objectives

Please indicate what your specific health goals are now and how committed you are to achieving those goals.

Terms Of Acceptance

When a patient seeks health care/treatment or health recommendations from On Site Health Care Services and accept a patient for such care, it is essential for both to be working towards the same objective.

We have one goal: To support the patient or client in restoring the body to optimal health using an inclusive approach of natural therapies and solutions.

On Site Health Care Services may recommend health products, treatment or care beyond what the patient has initially requested because it may support the patient's body in reaching optimal health.

The patient may decline any recommendation made by On Site Health Care Services. On Site Health Care Services may share product websites for the patient to learn more about a certain natural solution or therapy.

On Site Health Care Services will not solicit business opportunities. For more information on the solutions and therapies On Site Health Care Services may recommend, visit www.thegoodnewsdr.com.

Financial Arrangements

On Site Health Care Services offers conservative fees. We want to make sure that our patients are able to receive the needed care in an affordable manner.

On Site Health Care Services does not accept insurance or Medicaid. Payment must be made in the form of cash, check or credit card. In some cases, payment may be required prior to treatment or care.

If you have insurance coverage, On Site Health Care Services will provide a bill and receipt of payment for you to submit to your insurance company for possible reimbursement. In the event of discontinuation of care, you will be billed for any outstanding balance and payment is due within 60 days of your notice of discontinuation.

If your bill remains unpaid after 120 days and no satisfactory payment arrangements have been made towards reconciling it, then the debt on your account may be assigned to a collection agency.

I have read and understand the Terms of Acceptance and Financial Arrangements above and give the doctor permission to evaluate me.

I further agree to the fee schedule set forth by On Site Health Care Services and will ultimately be the party that is financially responsible for this account.

Print Patient Name:____

Patient Signature (or Parent/Guardian): _______________________________________ Date: _____________

Privacy Notice

We recognize and respect the privacy expectations of today's consumers and the requirements of applicable federal and state privacy laws. We believe that making you aware of how we use your non-public Personal Information, and to whom it is disclosed, will form the basis for a relationship of trust between us and the public that we serve. This Privacy Statement provides that explanation. We reserve the right to change this Privacy Statement from time to time consistent with applicable privacy laws.

In the course of our business, we may collect Personal Information about you from the following sources:

- From applications or other forms we receive from you or your authorized representative;
- From your transactions with or from the services being performed by us, our affiliates or others;
- From our internet websites;
- From the public records maintained by governmental entities that we either obtain directly from those entities or from our affiliates or others; and
- From consumer or other reporting agencies.

OUR POLICIES REGARDING THE PROTECTION OF THE CONFIDENTIALITY AND SECURITY OF YOUR PERSONAL INFORMATION

We maintain physical, electronic and procedural safeguards to protect your Personal Information from unauthorized intrusion. We limit access to the Personal Information only to those employees who need such access in connection with providing products or services to you or for other legitimate business purposes.

OUR POLICIES AND PRACTICES REGARDING THE SHARING OF YOUR PERSONAL INFORMATION

We may share your Personal Information with our affiliates, such as medical doctors, radiologists and/or other chiropractors for the purpose of rendering patient care. We may also disclose your Personal Information as applicable to:

- Your employer as related to Workers' Compensation injuries, and
- Attorneys as related to personal injury/automobile accident cases.

In addition, we will disclose your Personal Information when you direct or give us permission, when we are required by law to do so, or when we suspect fraudulent or criminal activities. We also may disclose your Personal Information when otherwise permitted by applicable privacy laws, for example, when disclosure is needed to enforce our rights arising out of any agreement, transaction or relationship with you.

RIGHT TO ACCESS YOUR PERSONAL INFORMATION AND ABILITY TO CORRECT ERRORS OR REQUEST CHANGES OR DELETION

You are afforded the right to access your Personal Information and, under certain circumstances, to find out to whom your Personal Information has been disclosed. Also, you are afforded the right to request correction, amendment or deletion of your Personal Information. We reserve the right, where permitted by law, to charge a reasonable fee to cover the costs incurred in responding to such requests. Anyone wishing to obtain a copy of their records must sign a release form. All requests must be made in writing via mail, fax or in person.

Print Patient Name:____

Patient Signature (or Parent/Guardian): ______________________________________ Date: ______________

Patient Consent Form

FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT ANALYSIS, TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS.

I, ________________________ hereby state that by signing this consent and initialing each item, I acknowledge and agree as follows:

____ 1. The practice's Privacy Notice has been provided to me and I have carefully read it prior to my signing this consent.

____ 2. The practice reserves the right to change its privacy practices that are described in its privacy notice, in accordance with applicable law.

____ 3. I understand that, and consent to, the following appointment communications and reminders that will be used by the practice:

- Postcards mailed to the addressee(s) I have provided.
- Telephoning me at the number(s) I have provided and leaving messages for me on my answering machine or with the individual answering the phone.
- Text messages at the number(s) I have provided.
- E-mail at the email address(s) I have provided.

____ 4. The practice may use and/or disclose my Personal Health Information (PHI) (which includes information about my health or condition, analysis, and the treatment provided to me) in order for the practice to make analyses about my condition(s), treat me, obtain payment for that treatment/care, and as necessary for the practice to conduct its specific health care operations.

____ 5. I understand that I have the right to request that the practice restrict how my PHI is used and/or disclosed except to obtain payment for treatment provided. However, the practice is not required to agree to any restrictions that I have requested, and I have the right to refuse treatment.

____ 6. I understand that this consent is valid as long as I am a patient in this office. I further understand that I have the right to revoke this consent, in writing at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the practice has already taken action in reliance on this consent. If I revoke this consent at any time, the practices has the right to refuse to treat me.

____ 7. I give On Site Health Care Services permission to treat me in a private room while leaving the door ajar. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a private room for these conversations.

____ 8. The doctor recommends that a spouse/partner (if applicable) be present at my report of findings visit; therefore I hereby give permission for my protected health information to be disclosed at that time and at any time my spouse/partner contacts the office to check on my status.

I have read and understand the above statements. I understand that I have the right to refuse to sign this authorization. If I choose to decline signing this consent form, this practice will not treat me.

Print Patient Name:____

Patient Signature (or Parent/Guardian): ____ Date: ______________

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 risks associated with the 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 will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a 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 health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in 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 to strokes, there is a rare but serious condition known as an “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 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 headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use for major GI events of the entire (upper and lower) GI tract was 1219 events/per one million persons/year and risk of death has been estimated as 104 per one million users.

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 content, 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 condition(s) for which I seek chiropractic care from this office.

Print Patient Name:____

Patient Signature (or Parent/Guardian): ____________________________________ Date: ____________