i am wellness™
HOLISTIC HEALTH CENTER

Outline of Procedures for New Chiropractic Patients

Thank you for your interest in becoming a patient in our clinic. For the majority of you, someone that you know has referred you to our office after receiving help with their own health challenges. We sincerely appreciate our patients who enthusiastically recommend their friends and loved ones to our office and we will work hard to make sure that you get the help that you need. Your path to improved health is simple and we've outlined the process below.

STEP 1: **All new patients are required to thoroughly and honestly complete and sign this New Patient Intake packet prior to your initial visit. These forms may take up to 30 minutes to complete.** Please print them, fill them out and arrive with these forms completed to your appointment. If forms are incomplete, you will be asked to complete them in the office prior to seeing the doctor. This will cut into your available time with the doctor. In fairness to the other patients that have been scheduled to see the doctor that day, it may be necessary to reschedule your initial visit for another day and you will be charged for your appointment.

STEP 2: In addition to the information that we'll be gathering from your intake questionnaire, your doctor or his assistant will consult with you regarding important aspects of your history. Once we understand your needs and goals, your doctor may recommend additional diagnostic procedures **to uncover the root causes of your concerns** in order to determine if our care is appropriate for you.

*If your case requires immediate attention, "quick start" protocols may be administered, however most new practice members will start receiving care after the doctor has taken sufficient time to fully evaluate all the examination results and derived a care program specifically for you.

STEP 3: At the conclusion of your initial visit, you will be scheduled to return on a subsequent day for a Report of Findings appointment where you will be taught what you can do to get the best possible results in the shortest period of time at the least possible expense. The doctor will inform you of your examination results and whether or not our office will accept your case. You will also be advised concerning various payment options. **If you are married or have another advisor who you would like to have with you on this visit, we highly encourage you to invite them to join you so that joint decisions can be made and care started.**

New Patient Health Profile

Name: _____ Age:_____ Date of Birth:_____

Address:_____ City:_____ State: ____ Zip:_____

Home phone:_____ Work phone:_____ Cell phone:_____

Best time and # to contact: _____ Email address:_____

Social Security #: _____ Sex: M F Marital Status: M W S

Occupation:_____ Employer: _____

Spouse's Name: _____ Spouse's Employer: _____

Children's Names and Ages: _____

Who may we thank for referring you to our office? _____

Payment Policies

If your condition is the result of a recent Motor Vehicle collision, PLEASE STOP NOW AND REQUEST DIFFERENT INTAKE FORMS from our office as different policies and procedures are required in Personal Injury situations. We are not in-network providers for any insurance companies and as such, all payments for chiropractic exams, consultations, adjustments, supports and other modalities are due at the time of service or prior to services being rendered. We accept cash, check, Visa, MasterCard and American Express. We will provide all patients with documentation of your charges and payments so that you can submit them to your insurance company for possible reimbursement.

Reasons for consulting our office:

Health Concerns: List health concerns In order of severity	Rate of Severity 1=mild 10 = worst imaginable	When did this episode start?	If you've had the condition before when?	Are symptoms constant or intermittent?
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____

Is your primary complaint the result of an auto accident or work injury? Y N If so, when? _____

Is there a family history of similar problems? (explain)_____

Is there any chance that you are pregnant today? Y N

Have you been to a chiropractor before? Y N If so, who? _____ When? _____

Other Doctors you have seen for this condition:

1. Name/Address _____ 2. Name/Address_____

Date: _____ Diagnosis: _____ Date: _____ Diagnosis: _____

What was done? _____ What was done? _____

Result? _____ Result? _____

Please check all the Alternative Treatments you have tried for your condition(s)

☐ None	☐ Massage	☐ Yoga	☐ Environmental medicine
☐ Chiropractic	☐ Rolfing	☐ Hypnosis	☐ Nutritional Therapy
☐ Acupuncture	☐ Reiki	☐ Ayurveda	☐ Biological Dentistry
☐ Iridology	☐ Homeopathy	☐ Light therapy	☐ IV Chelation Therapy
☐ Colonics	☐ Biofeedback	☐ Meditation	☐ Naturopathic medicine

Establishing Your Health and Wellness Goals

After many years in private practice, I have had the opportunity to work with thousands of patients and have seen many patients achieve significant improvement while others have become frustrated or distracted and failed in their attempt to get well. After careful review, I have discovered several reasons why some people succeed and why others fail. The most important determining factors are a clear and powerful desire to improve and specific goals and action steps to accomplish those goals. When you have made a decision to change and you know your reasons, you create an internal power that can propel you past perceived obstacles to achieving health and wellness.

Therefore, to help you make significant changes in your present health, I want to ask you a few very important questions. I want you to be honest with yourself and really dig deep inside yourself for the answers.

What do you hope to achieve by seeking care in our office? _____
_____

If I had a magic wand and could erase three of your health problems, what would they be?

1. _____
2. _____
3. _____

Rate your current level of commitment to doing what it takes to get well 1 2 3 4 5 6 7 8 9 10

List up to 5 things that you have *<u>been unable</u>* to do as a result of your present symptoms. Please be specific. (Use extra pages if necessary)

_____
_____
_____
_____
_____
_____
_____

List up to 5 things that you plan to do once you are feeling better. Please be specific. (Use extra pages if necessary)

_____
_____
_____
_____
_____
_____

Are there any other health goals you want to achieve?

_____
_____
_____

Structural Health Questionnaire

Have you been told that your birth process was complicated? _____

Have you suffered from significant falls or accidents in your life? _____

Do you play sports currently or did you as a youth? _____

Have you ever sprained a joint or fractured a bone? _____

Have you ever been diagnosed with scoliosis, osteoporosis, disc degeneration, arthritis or any other bone or joint disease? _____

Have you had any surgeries on your bones or joints? _____

Have you had any car accidents (even minor ones)? _____

How often do you engage in vigorous physical exercise? _____

Do you sit or stand for prolonged periods of time? _____

Please score the following list of symptoms based on how you have felt over the past 3-4 months.

Key:	**0=No, symptom does not occur**	**1=Yes, minor or mild symptom, rarely occurs (monthly)**
	2=Moderate symptom, occurs occasionally (weekly)	**3=Severe symptom, occurs frequently (daily)**

1. 0 1 2 3 Neck pain
2. 0 1 2 3 Upper or Mid back pain
3. 0 1 2 3 Lower back pain
4. 0 1 2 3 Joints or muscles stiff in the morning
5. 0 1 2 3 Difficult to pick something up off of the floor
6. 0 1 2 3 Painful joint motion
7. 0 1 2 3 Difficulty opening jars that were previously easy
8. 0 1 2 3 Joint swelling or stiffness in your fingers, hands, wrists, elbows, shoulders,
9. 0 1 2 3 Joint swelling or stiffness in your toes, feet, ankles, knees or hips
10. 0 1 2 3 Difficult going from sitting to standing
11. 0 1 2 3 Prolonged sitting increases pain or symptoms
12. 0 1 2 3 Shooting/aching/tingling sensations down one or both legs
13. 0 1 2 3 Burning/throbbing/stabbing muscle pains
14. 0 1 2 3 Muscle cramps or spasms
15. 0 1 2 3 Points on your body that are extra sore to touch
16. 0 1 2 3 Tension or headaches that start in the neck
17. 0 1 2 3 Jaw clicking or popping
18. 0 1 2 3 Difficulty opening your mouth and chewing
19. 0 1 2 3 Numbness in either hand or wrist
20. 0 1 2 3 Limping or favoring one leg

Total Structural Symptom Score _____

Lifestyle Stress Survey

Please answer the questions on a scale of 1 to 10, where 1 represents absolute disagreement and 10 represents absolute agreement.

Section 1 – Physical Health

1. I am a physically fit person and engage in formal exercise on a regular basis.
   [1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
2. I have a physically attractive body that I am proud to look at in the mirror.
   [1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
3. I have not had many traumas in my life (auto accidents, broken bones, bad falls etc)
   [1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
4. I get at least 7 hours of sleep, 7 days per week.
   [1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
5. I have received regular chiropractic care within the last 5 years.
   [1] [2] [3] [4] [5] [6] [7] [8] [9] [10]

Section 1 Total _____

Section 2 – Emotional/Mental Health

1. I am a calm, peaceful person. I can shut my mind off and focus my mind at will.
   [1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
2. I practice some form of mental relaxation (meditation, yoga, breathing exercises, prayer) regularly.
   [1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
3. Most of the time, I am truly happy and feel a sense of purpose in my life.
   [1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
4. I have healthy relationships and a rich social network of friends and activities.
   [1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
5. I am organized, have time for myself, and can prioritize the important tasks in my life.
   [1] [2] [3] [4] [5] [6] [7] [8] [9] [10]

Section 2 total _____

Section 3 – Chemical/Nutritional Health

1. I eat 4-6 small meals daily and properly combine healthy proteins, vegetables, carbs and fats.
   [1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
2. I supplement daily with good supplements such as multivitamins, antioxidants, fatty acids, vitamin D, and probiotics.
   [1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
3. I do not take medications for chronic medical problems such as digestive disorders, cardiovascular problems, headaches, chronic pain, blood sugar problems, chronic fatigue, immune problems or chronic infections, hormonal imbalances etc.
   [1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
4. I do not smoke cigarettes.
   [1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
5. I drink water as my primary beverage and consume at least 64 oz per day.
   [1] [2] [3] [4] [5] [6] [7] [8] [9] [10]

Section 3 Total _____

Grand Total of all Sections _____

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 understand and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect own 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 dwelling 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 hot/cold packs, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as a cervical arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a clot with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care of 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. 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 per one million to two million cervical adjustments.

It is also important to that you understand that 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 medications, 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 of future recommendation to receive chiropractic care and nutritional and lifestyle advice 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 care from this office.

Patient Name: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

Financial Policies

In an effort to maintain compliance with various state and federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines, we have adopted the following financial policies.

- Our clinic has established a single fee schedule that applies to all patients for each service provided.
- You may be entitled to a network or contractual discount under the following circumstances:
    - You are covered by a State or Federal program with a mandated fee schedule i.e. Medicare
    - You are a member of our Wellness Circle Program or any other Discount Medical Plan Organization that our office participates with.
- If you do not meet any of the circumstances above, you will be required to pay the full fee at the time of service unless we have approved in advance to accept a partial payment.
- Missed Appointments - Failing to provide adequate notice (24 hours) of your inability to keep a regularly scheduled appointment will incur a charge equal to 50% of the scheduled service.
- A $25 charge will be applied in the event of a check returned with Not Sufficient Funds.
- Refunds – There are no refunds extended for services that have already been received. If you have elected to pre-pay for any part of your care, unused portions of your care MAY be eligible for a refund. The conditions for a refund will be carefully explained prior to your agreement to receive "pre-pay eligible" services. Refunds for supplements must meet the following criteria:
    - The bottle or package must be unopened.
    - The return must be within 30 days of purchase and the product must not have passed its expiration date.
    - A 15% restocking fee will be applied unless the product is being exchanged for another product at that time.
- If your account is not paid within 30 days of the date of service and no financial arrangements have been agreed upon in writing, a finance charge of 2% per month (annual percentage rate 24%) of the unpaid balance will be added monthly. Should the balance remain unpaid for 60 days after the date of service the balance will be sent to collections and the responsible party agrees to pay an additional 40% collection fee and all legal fees of collection, with or without suit, including attorney fees and court costs.
- **Special information for Auto Accidents:** Our office will submit claims for you if you have been injured in an Auto Accident. Utah Personal Injury Protection Benefits include a minimum of $3,000 for initial health care expenses. Your individual policy limits may be higher. Once the PIP policy limit is reached, patients will be required to pay for all services at the time they are rendered or establish a payment plan with our office. We may elect to continue to care for you on "lien" if you are working with an approved attorney. It is the patient's responsibility to fill out and return their PIP benefits application to their insurance company in a timely manner. Your insurance company will not pay on claims until this application has been received. We suggest you provide a copy of the completed application to our office to help expedite payment. Since we are unaware of other health services you may have received, we cannot be responsible to keep track of your PIP balance/benefits.
- If this is a personal injury case, signing this agreement acts as a lien and all parties will be paid on services rendered.
- I hereby assign all health eligible insurance benefits to which I am entitled to my physician at I Am Wellness, 485 S. 100 E. Bountiful, UT 84010. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment, via Fax Transmittal, e-mail or hard copy. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my insurance status.

Signature of Responsible Party:_____ Date:_____

HIPAA Privacy Policies

At I Am Wellness we understand that your medical and health information is private. We know that respect for that privacy is a critical part of our relationship. We are committed to protecting the privacy of your protected health information that is in our possession. We follow strict federal and state laws that require us to maintain confidentiality of your health information. This "Notice of Privacy Practices" was created to help you understand our legal duties to protect your health information, as well as your rights in regards to your health information.

How We May Use Your Health Information

When you receive care at our office we may use your health information for treating you, billing for services rendered and conducting our normal business operations. The following are examples of how we use and disclose your health information: Treatment- We keep records of the care and services provided to you. We use these records to deliver quality care to meet your needs. We may share your health information with a specialist or representative who will assist in your treatment. Payment- We keep billing records that include payment information and documentation of services provided to you. Your information may be used to obtain payment from your insurance company or any third party. We may also contact your insurance company to verify coverage for your care or to notify them of upcoming services that need prior notice or authorization. Health Care Operations- We use health information to continually improve the quality and effectiveness the health care services we provide. We may use your health information to train staff and students, provide customer services, and conduct required business duties.

We may also use your health information to: Recommend treatment alternatives, tell you about health services and products that may benefit you, share information with family or friends who are involved in your care or payment for your care and share information with third parties who assist us with treatment, payment and health care operations.

Specific Agreements (Please Circle)

Y / N - I agree to allow I Am Wellness to call my home and/or work to remind me of appointments or advise me of issues related to my care.

Y / N - I agree to allow I Am Wellness to correspond to me via email regarding my personal health matters (lab reports etc.) as well as other information regarding general health issues.

We may sharing your health information: For public health purposes such as reporting communicable diseases, work-related illness and injuries, or other diseases and injuries permitted by law; reporting deaths; and reporting reactions to drugs or problems with medical devices, to protect victims of abuse, neglect or domestic violence, for lawsuits and similar proceedings, when requested by law enforcement as required by law or court order, for Workers' Compensation or other similar programs if you are injured at work. Our office will obtain your written authorization before using or disclosing your health information other than those instances listed above (or as otherwise permitted and required by law). You may revoke your authorization at any time with a written statement.

Our Privacy Responsibilities We are required by law to do the following: Maintain the privacy or your health information, provide this notice that describes the ways we may use and share your health information, follow the terms of the notice currently in effect.

Your Individual Rights You may request restrictions on how we use and share your information. (However we may not be required by law to honor these requests.) You may inspect and request a copy of your health information (Fees may apply). You may make a written request for corrections or additions to your health information. You may request and additional copy of this notice. You may request an accounting of certain disclosures of your health information made by us. This would exclude an accounting of disclosures made for treatment, payment or health care operations. This excludes disclosures prior to April 14, 2007.

Contact Us

We at I Am Wellness take the matters described in this "Notice of Privacy Practices" very seriously because of our relationship with you and the legal requirements that we comply with this notice. We reserve the right to update and make changes to this notice at any time. You may request a copy of this notice from any employee at our office.

If you would like further information about your privacy rights, are concerned that your privacy rights have been violated, or disagree with a decision that we made about access to your health information, please feel free to contact our Privacy Coordinator:

Tammie Duggar
(801) 677-7878

I have received/reviewed a copy of this office's Notice of Privacy Practices.

_____ _____

Signature of responsible party Date

Arbitration Agreement

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, including whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence-giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.
The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here _____ Effective as of the date of first professional services. If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

_____ _____ _____

Signature of responsible party | Date | Indicate relationship if signing for patient

_____ _____

Signature of office representative | Date