Indigo CHIROPRACTIC
"Your Path To Wellness!"

Informed Consent to Chiropractic Treatment

Chiropractic is a non-surgical, non-invasive procedure and has one of the safest records in health care. As with any health care specialty, we cannot promise a cure, but we will give you the best care possible and discuss any questions or concerns with you.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any diseases or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

I understand, as with any health care procedures, that there are certain complications which may arise during chiropractic treatments. Patients may experience temporary symptoms such as an increase in soreness following a massage, manipulation or traction. In addition, physiotherapy such as ice, heat, ultrasound or electrical muscle stimulation may irritate skin. There have been rare cases where adjustments may have aggravated a bulging or herniated disc or caused a rib fracture. On extremely rare occasions, adjustments to certain areas of the cervical spine have been related to a compromise of the vertebral artery and possible stroke or stroke-like symptoms. Tests, with or without X-rays, will be performed on you. Those results, along with information you provided will help determine if you are in a risk group. You will be informed if you are and treatment will be amended accordingly.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose, and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my complete satisfaction.

I have read (or have had read to me) the above explanation of the chiropractic treatments. By signing below, I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I hereby give my informed consent to examination and treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

Printed Name of Patient	Printed Name of Legal Representative
x _____	_____
Signature of Patient or Legal Representative	Date
x _____	_____
Staff Witness	Date

9755 N. 90th Street, Suite A-203
Scottsdale, AZ 85258

Iain Simpson, D.C.
(480) 451-3500

New Patient Information

Date:_____

Legal First Name:_____ M.I.:_____ Last Name:_____

Nickname:_____ Date of Birth:_____ Sex: ☐Male ☐Female

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Other

Are you: ☐Left Handed ☐Right Handed ☐Ambidextrous

Home Phone: ( )_____ Cell Phone: ( )_____

Email Address:_____

Street Address:_____ Apt# / Unit#:_____

City:_____ State:_____ Zip:_____

Mailing Address (if different from street address):_____

City:_____ State:_____ Zip:_____

Employed: ☐Full Time ☐Part Time ☐Retired ☐Unemployed ☐Student ☐Other:_____

Occupation:_____ Employer:_____

Work Phone: ( )_____ Ext._____

Emergency Contact:_____ Relationship to You:_____

Emergency Contact Phone: ( )_____ ☐Home ☐Cell ☐Work

How did you hear about our office?_____

9755 N. 90th Street, Suite A-203
Scottsdale, AZ 85258

Iain Simpson, D.C.
(480) 451-3500
Rev. 12/18/2014

Indigo CHIROPRACTIC
"Your Path To Wellness!"

Insurance Information

☐New Patient ☐Patient Update

Patient Name:_____ Patient Date of Birth:_____

Do you have insurance? ☐Yes ☐No **PRIMARY** Insurance Company:_____

Subscriber's Name:_____ Subscriber's DOB:_____

Policy/ID#:_____ Group#:_____

Policy Holder is: (Check One) ☐ **Self** ☐ **Spouse** ☐ **Parent or Guardian** ☐ **Other**

Assignment and Release
I, the undersigned party, certify that I (or my dependent) have insurance coverage with the above company. I authorize and request that payments under my medical insurance program be made directly to Indigo Chiropractic for any services furnished to me. I understand that I am financially responsible for all charges whether or not paid by insurance. I consent to the release of all information necessary to secure payment. I authorize the use of this signature on all insurance submissions. I further permit copies of this authorization to be used in place of the original.

_____ _____ _____
Responsible Party Signature | Date | Relationship to Insured (Please list one: Self, Spouse, Child, Other)

Do you have secondary or supplemental insurance? ☐Yes ☐No

SECONDARY Insurance Company:_____

Subscriber's Name:_____ Subscriber's DOB:_____

Policy/ID#:_____ Group#:_____

Policy Holder is: (Check One) ☐ **Self** ☐ **Spouse** ☐ **Parent or Guardian** ☐ **Other**

Assignment and Release
I, the undersigned party, certify that I (or my dependent) have insurance coverage with the above company. I authorize and request that payments under my medical insurance program be made directly to Indigo Chiropractic for any services furnished to me. I understand that I am financially responsible for all charges whether or not paid by insurance. I consent to the release of all information necessary to secure payment. I authorize the use of this signature on all insurance submissions. I further permit copies of this authorization to be used in place of the original.

_____ _____ _____
Responsible Party Signature | Date | Relationship to Insured (Please list one: Self, Spouse, Child, Other)

Chief Complaint

☐New Patient ☐Patient Update

Patient Name:_____ Date:_____

Reason for visit:_____

Date of Injury or Symptom Onset:_____

Type of Injury: ☐Sports ☐Job Accident ☐Car Accident
☐Other:_____

Describe how your symptoms first began:_____

_____

_____

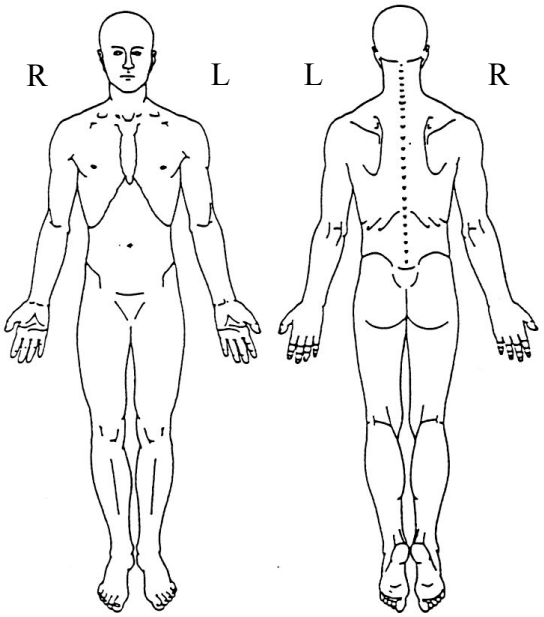
☐Gradual ☐Rapid ☐Sudden ☐Progressive over time

Severity of Pain: 0 (No Pain) to 10 (Severe Pain)

○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○

Type of Pain: ☐Dull ☐Aching ☐Sharp ☐Shooting
☐Burning ☐Throbbing
☐Stiffness ☐Tingling ☐Numbness
☐Other:_____

Mark the areas of your symptoms on the figure below:



Does the pain Radiate to any other areas of your body? ☐Yes ☐No

Describe where:_____

Mark how often you have this pain: ☐Constant 100% ☐Frequent 75% ☐Intermittent 50% ☐Occasional 25% ☐Rare 10%

Describe what makes your pain worse:_____

Describe what makes your pain better:_____

Your pain interferes with: ☐Work ☐Daily Routine ☐Recreation ☐Sleep ☐Other:_____

Previous treatments you have received for this complaint: ☐None ☐Medications ☐Chiropractic ☐Physical Therapy
☐Surgery ☐Other:_____

List other Doctor(s) you have seen for this condition:

Name:_____ Phone Number: ( ) _____

Name:_____ Phone Number: ( ) _____

Indigo CHIROPRACTIC
"Your Path To Wellness!"

9755 N. 90th Street, Suite A-203
Scottsdale, AZ 85258

Iain Simpson, D.C.
(480) 451-3500

Health History

Patient Name:_____ Date:_____

Has any blood relative ever had:

	Who		Who
Cancer	_____	Stroke	_____
Diabetes	_____	Arteriosclerosis	_____
Heart Trouble	_____	Arthritis	_____
High Blood Pressure	_____	Spinal Curvature	_____

Check the following if you have or if you ever have had:

☐Alcoholism
☐Anemia
☐Appendicitis
☐Arteriosclerosis
☐Arthritis
☐Asthma
☐Cancer
☐Chorea
☐Cold Sores
☐Diabetes
☐Diphtheria
☐Eczema
☐Emphysema
☐Epilepsy
☐Gout
☐Heart Disease
☐Hepatitis
☐HIV/AIDS
☐Influenza
☐Lumbago
☐Measles
☐Migraines
☐Miscarriage
☐Multiple Sclerosis
☐Mumps
☐Pleurisy
☐Pneumonia
☐Polio
☐Rheumatic Fever
☐Scarlet Fever
☐Stroke
☐Tuberculosis
☐Typhoid Fever
☐Ulcers
☐Whooping Cough

Check the following symptoms you have had within the past year:

General
☐Allergy
☐Chills
☐Convulsions
☐Depression
☐Dizziness
☐Fainting
☐Fatigue
☐Fever
☐Headache
☐Loss of sleep
☐Loss of weight
☐Neuralgia
☐Sweats
☐Tremors

Cardiovascular
☐Angina
☐Ankle swelling
☐Chest pain
☐High blood pressure
☐Low blood pressure
☐Poor circulation
☐Rapid heartbeat
☐Slow heartbeat

Muscle & Joint
☐Arthritis
☐Bursitis
☐Foot trouble
☐Hernia
☐Low back pain
☐Lumbago
☐Mid back pain
☐Neck pain
☐Shoulder pain

Pain or Numbness in:
☐Arms
☐Elbows
☐Feet
☐Hands
☐Hips
☐Knees
☐Legs
☐Shoulders
☐Tailbone

☐Poor Posture
☐Sciatica
☐Spinal Curvature
☐Swollen Joints

Eyes, Ears & Nose
☐Asthma
☐Colds
☐Crossed eyes
☐Deafness
☐Dental decay
☐Earache
☐Ear discharge
☐Enlarged glands
☐Enlarged thyroid
☐Eye pain
☐Failing vision
☐Far sightedness
☐Gum trouble
☐Hay fever
☐Hoarseness
☐Nasal obstruction
☐Near sightedness
☐Nosebleeds
☐Sinus infection
☐Sore throat
☐Tinnitus
☐Tonsillitis

Respiratory
☐Chest pain
☐Chronic cough
☐Difficulty breathing
☐Spitting up blood
☐Spitting up phlegm
☐Wheezing

Gastro-intestinal
☐Belching or gas
☐Crohn's disease
☐Colitis
☐Colon trouble
☐Constipation
☐Diarrhea
☐Difficult digestion
☐Gall bladder trouble
☐Hemorrhoids
☐Jaundice
☐Liver trouble
☐Nausea
☐Poor appetite
☐Rectal pain
☐Stomach pain
☐Vomiting

Skin
☐Bruise easily
☐Dryness
☐Hives or allergy
☐Itching
☐Rashes
☐Varicose veins

Genito-urinary
☐Bed wetting
☐Bladder control
☐Blood in urine
☐Discolored urine
☐Frequent urination
☐Kidney infection
☐Painful urination
☐Prostate trouble

Women Only
☐Cramps
☐Excessive flow
☐Hot flashes
☐Irregular cycles
☐Menopause
☐Painful flow
☐Vaginal discharge

Patient Name:_____ Date:_____

	Yes	No
Have you ever been knocked unconscious?	☐	☐
Do you use a cane or other support?	☐	☐
Have you been treated for a spine or nerve disorder?	☐	☐
Have you ever had a fractured / broken bone?	☐	☐
Have you been hospitalized for anything other than surgery?	☐	☐
Do you now take vitamins or minerals?	☐	☐

Habits:

	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

Date of Last:

	< 6 months	6-18 months	>18 months	Never
Spinal Examination	☐	☐	☐	☐
Physical Examination	☐	☐	☐	☐
Blood Test	☐	☐	☐	☐
Chest X-ray	☐	☐	☐	☐
Spinal X-ray	☐	☐	☐	☐
Urine Test	☐	☐	☐	☐

Are you pregnant? ☐No ☐Not sure ☐Yes, _____weeks

PLEASE LIST ALL SURGERIES YOU HAVE HAD

Type:_____ When:_____ Doctor:_____

Type:_____ When:_____ Doctor:_____

PLEASE LIST ALL PREVIOUS ACCIDENTS AND FALLS

What:_____ When:_____

What:_____ When:_____

PLEASE LIST ANY MEDICATIONS AND/OR VITAMINS YOU TAKE

What:_____ Dosage/Frequency:_____ Doctor:_____

What:_____ Dosage/Frequency:_____ Doctor:_____

What:_____ Dosage/Frequency:_____ Doctor:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have read a copy of the office's Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment, and in the performance of health care operations by Indigo Chiropractic. This Notice of Privacy Practices has been provided to me.

I consent to the use or disclosure of my protected health information for the above-named purposes and those contained within the Notice of Privacy Practices.

_____ _____

(Print Patient Name) (Today's Date)

_____

(Signature of Patient or Legal Guardian)

_____ _____

(Printed Name if signed on behalf of the patient) (Relationship)

9755 N. 90th Street, Suite A-203
Scottsdale, AZ 85258

Iain Simpson, D.C.
(480) 451-3500

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We are required by law to provide you with this notice that explains our privacy practices with regard to your medical information and how we may use and disclose your protected health information for treatment, payment, and for health care operations, as well as for other purposes that are permitted or required by law. You have certain rights regarding the privacy of your protected health information and we also describe them in this notice.

WAYS IN WHICH WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION: The following paragraphs describe different ways that we use and disclose your protected health information. We have provided an example for "Treatment", "Payment" and "Health Care Operations", but these examples are not meant to be exhaustive. We assure you that all of the ways we are permitted to use and disclose your health information fall within one of these categories.

Treatment - We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. We will also disclose your health information to other physicians who may be treating you. Additionally, we may from time to time disclose your health information to another physician who we have requested to be involved in your care. *For example* – we would disclose your health information to a specialist to whom we have referred you for a diagnosis to help in your treatment.

Payment - We will use and disclose your protected health information to obtain payment for the health care services we provide you. *For example* – we may include information with a bill to a third-party payer that identifies you, your diagnosis, procedures performed, and supplies used in rendering the service.

Health Care Operations - We will use and disclose your protected health information to support the business activities of our practice. *For example* – we may use medical information about you to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you. In addition, we may disclose your health information to third party business associates who perform billing or consulting services for our practice.

OTHER WAYS WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Appointment Reminders - We will use and disclose your protected health information to contact you as a reminder about scheduled appointments or treatment. Appointment reminders are only performed upon request by you.

Your individual practitioner may contact you regarding treatment options, specials, birthday greetings, office hour changes, event notices, etc. Typically this is done by e-mail, but can be done by postcards, letters, texts or calls. Please notify us in writing if you do not wish to receive these communications. Upon written request, this office will withhold any or all such communications.

Others Involved In Your Care - We will use and disclose your protected health information to a family member, a relative, a close friend, or any other person you identify that is involved in your medical care or payment for care.

SPECIAL SITUATIONS: We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations.

As Required by Law - We will use and disclose your protected health information when required by federal, state or local Law. You will be notified of any such disclosures.

Public Health Risk - We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Military, Veterans, National Security and Intelligence - If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

Worker's Compensation - We will use and disclose your protected health information for worker's compensation or similar programs that provide benefits for work-related injuries or illness.

Inmates - We will use and disclose your protected health information to a correctional institution or law enforcement official if you are an inmate of that correctional institution or under the custody of the law enforcement official. This information would be necessary for the institution to provide you with health care.

Health Oversight Activities - We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes - If you are involved in a lawsuit or dispute, we may disclose health information about you in response to a court order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement - We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Abuse or Neglect - We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure to a law enforcement official only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

OTHER USES AND DISCLOSURES OF HEALTH CARE INFORMATION: We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written authorization.

YOUR HEALTH INFORMATION RIGHTS: Although your health record is the physical property of the health care practitioner or facility that compiled it, the information belongs to you. You have the right to the following:

A Paper Copy of This Notice - You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking any employee of this office at your next visit or by calling and asking us to mail you a copy.

Inspect and Copy - You have the right to inspect and copy the protected health information that we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other records we use for making decisions about you. Any psychotherapy notes that may have been

included in records we received about you are not available for your inspection or copying by law. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request.

If you wish to inspect or copy your medical information, you must complete our "Records Release" form and submit it to our office, located at: 9755 N. 90th Street, Suite A-203, Scottsdale, AZ 85258. You may mail in your request, or bring it to our office. We will have 30 days to respond to your request for information that we maintain at our practice site. If the information is stored off-site, we are allowed up to 60 days to respond but must inform you of this delay.

Request Amendment - You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing to your practitioner, stating exactly what information is incomplete or inaccurate and your reasoning that supports your request. We can only amend information that is kept by this office.

Request Restrictions - You have the right to request a restriction or limitation of how we use or disclose your medical information for treatment, payment, or health care operations. *For example* – you could request that we not disclose information about a prior treatment to a family member or friend who may be involved in your care or payment for care. Your request must be made in writing to our office.

We Are Not Required to Agree to Your Request - If we do agree, we will comply with your request unless that information is needed to provide you emergency treatment.

Right to Accounting of Disclosures - You have the right to request a list of the disclosures of your health information we have made outside of our practice that were not for treatment, payment, or health care operations. Your request must be made in writing and must state the time period for the requested information. You may not request information for any dates prior to April 14, 2003 (the compliance date for the federal regulation) nor for a period of time greater than six years (our legal obligation to retain information). Your first request for a list of disclosures within a 12-month period will be free. If you request an additional list within 12-months of the first request, we may charge you a fee for the costs of providing the subsequent list. We will notify you of such costs and afford you the opportunity to withdraw your request.

Request Confidential Communications - You have the right to request how we communicate with you to preserve your privacy. *For example* – you may request that we call you only at your work number, or by mail at a special address or postal box. Your request must be made in writing and must specify how or where to contact you. We will accommodate all reasonable requests.

Changes to This Notice - We reserve the right to change this notice, and to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the bottom right hand corner. You are entitled to a copy of the notice currently in effect.

File a Complaint - If you believe we have violated your medical information privacy rights, you have the right to file a complaint with our office or directly to the Department of Health and Human Services. To file a complaint with our office, contact your practitioner. You should know that there would be no retaliation for your filing a complaint.

USES OR DISCLOSURES NOT COVERED: Uses or disclosures of your health information not covered by this notice or the laws that apply to us may only be made with your written authorization. You may revoke such authorization in writing at any time and we will no longer disclose health information about you for reasons stated in your written authorization. Disclosures made in reliance on the authorization prior to the revocation are not affected by the revocation.