Application for Care at VIBRANT LIFE CENTER

Today's Date: _____ - _____ - _____

Name: _____ **Birthdate**: _____ **Age**: _____

SSN: _____-_____-_____ **Sex**: M or F

Marital Status (circle one): Single, Married, Widowed, Divorced, Living w Partner, Separated

Spouse's Name: _____

# of Children & Ages: _____

Mobile Phone: _____

E-mail: _____

Street Address:

_____

_____

City: _____

State: _____ **Zip**: _____

Home or Work Phone: _____

Employer: _____

Occupation: _____

COMPLAINT - *for prompt and accurate care, please notify staff if you are here due to an auto accident or workplace injury.*

1. What brought you in? Primary concern: _____

   _____

   Secondary: _____ Third: _____
2. On a scale of *1 (no pain)* to *10 (max. pain)*, please rate your above complaints. Please also indicate if each complaint is Chronic or Accident/Injury (of any kind), or O for Other.
   a. Primary Complaint: #_____ , *Chronic* *Accident/Injury* *Other*
   b. Second Complaint: #_____ , *Chronic* *Accident/Injury* *Other*
   c. Third Complaint: #_____ , *Chronic* *Accident/Injury* *Other*
3. When did your primary complaint (originally) start? _____
4. Is it a recurring problem? If so, how often does it occur and when? When was the last time it happened? _____

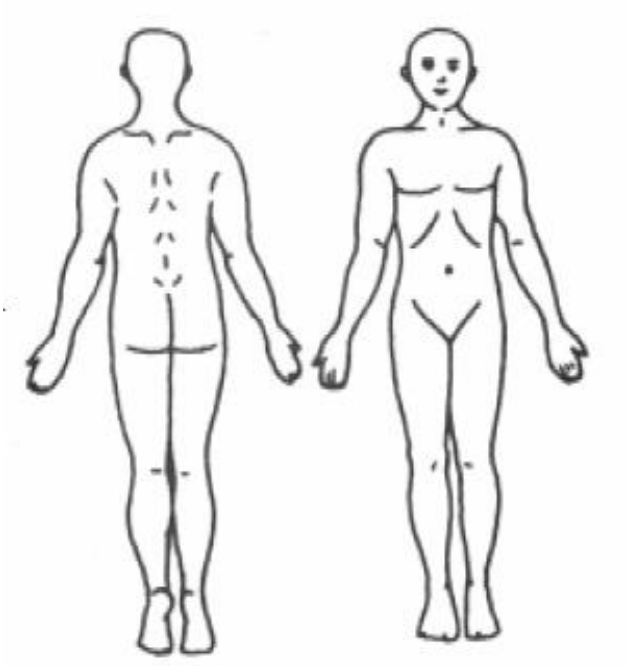
   _____
5. What time of day is your complaint at its worst? _____
6. If injured, how did the injury happen? _____

   _____
7. How long does the complaint usually last? _____

Any Additional Comments:

PREVIOUS TREATMENT

1. What other forms of treatment have you tried to treat this concern? (medicine, exercises, surgery, diet, etc.) _____
   _____
2. Who provided the treatment? (self, doctor, chiropractor, etc.) _____
3. If you tried an ongoing treatment (medicine, exercises, diet, etc.), how long did the treatment last? _____
4. If you had a surgery(ies), when was it? _____
5. Please explain the results of care (favorable, unfavorable, etc.): _____
   _____



CURRENT PAIN

PLEASE MARK the areas on the diagram with the following letters to describe your symptoms:

- R = Radiating
- B = Burning
- D = Dull
- A = Aching
- N = Numbness
- S = Sharp/ Stabbing
- T= Tingling

What relieves your symptoms?

_____

What makes them worse?

_____

How do you feel your complaint impacts your daily life? (*specific activities that are more difficult or can't be done, mental/emotional health, actions such as carrying or lifting, etc.)*

_____

_____

HEALTH AND FAMILY HISTORY

1. Have you ever been diagnosed with any of the following conditions? Please indicate a yes with a P for in the Past, C for Currently, OR no with N for Never have had:

____ Broken Bone ____ Dislocations ____ Tumors ____ Rheumatoid Arthritis

____ Fracture ____ Disability ____ Cancer ____ Heart Attack ____ Osteo Arthritis

____ Diabetes ____ Cerebral Vascular *Other Serious Conditions*:_____

_____

2. Please identify all past and any current conditions you feel may be contributing to your present problem, including injuries, surgeries, childhood diseases, adult diseases, etc.:

_____

_____

_____

3. Does anyone in your family suffer with the same or similar conditions? _____
4. If yes, what is their relation to you? _____
5. What kind of treatment did they have? _____
6. Any other hereditary conditions the doctor should be aware of? _____
7. Please circle any alcohol and drugs that you consume:
   - Smoking: cigars / vapes / pipe / cigarettes. How Often? _____
   - Weekly Alcoholic Beverages: none / 1-2 drinks / 3-6 drinks / 7-10 / 11+ drinks
   - Recreational Drug Use: daily / weekends / occasionally / never

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

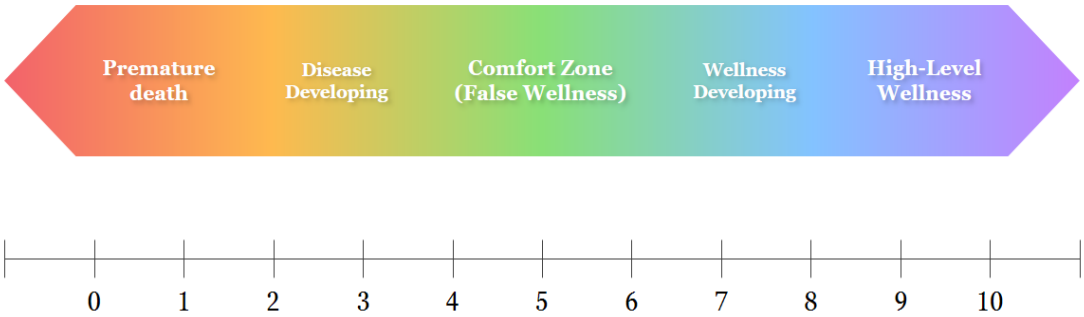
_____

_____

Please list any medications and supplements you take: _____

_____

HEALTH CONTINUUM



What number (from above) do you think represents your health today? _____

In what direction is your health currently headed? _____

What are your health goals?

- Immediate: _____
- Short Term: _____
- Long Term: _____

I hereby authorize payment(s) to be made directly to VIBRANT LIFE CENTER for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to VIBRANT LIFE CENTER for any and all services I receive at this office.

_____

Patient's Name

_____ _____-_____-_____

Patient or Patient's Legal Guardian's Signature Date Completed

_____ _____ - _____ - _____

Doctor's Signature Date Form Reviewed

INFORMED CONSENT

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 from major GI events of the entire (upper and lower) GI tract was 1219 events per one million person per 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.

Patient Name: _____ Signature: _____
Date____/____/____
Parent or Legal Guardian Name: _____ Signature: _____
Date ____/____/____

UNDERSTANDING COVERAGE AND COSTS

We are in every Minnesota based network. We will submit all insurance to help you get your claims paid. However, health plan benefits are just that, a *plan* of benefits. They do not cover everything. And, they typically are subject to out of pocket costs for deductible, copays and coinsurance before they will pay anything toward your bill. *It is YOUR responsibility to get us the information to help you*.

AUTO ACCIDENT Your Personal Injury Protection (PIP) fully covers your care here provided you file the claim in a timely fashion. Which means, within a couple months at most.

In Minnesota, all claims for PIP injuries are submitted **to your personal car insurance,** regardless of who is at fault in the accident, you are covered. Your own insurance is used for this and **the insurer, by law, can't raise your premiums because you made a PIP claim.** You don't even need to be IN a car. If you were hit by someone while walking, YOUR car insurance pays for your care. This is Minnesota **No-Fault** insurance law.

WORKERS' COMPENSATION Injuries on the job are covered 100%. But since 1996 you have only 12 weeks of care to get better. After which, you will be relegated to pain clinic care (injections, antidepressants, muscle relaxants). Please be attentive to your care plan to get the best result.

Please help us get you your benefits by giving us your insurance card, claim numbers, date of injury etc., as soon as possible. We will do everything we can to help you. Whether insurance pays or does not pay, **you are responsible for paying all service fees at Vibrant Life Center.** Possible service fees:

- Examination $97 - $280
- Radiographs $50 - $300 depending on views obtained.
- Adjustment $61-$77 (this could be $0 to $60+ depending on benefit plan)
- Extremity adjustment $45
- Traction, cervical or intersegmental $49
- Kinetic Activities, vibe plate $45
- 60 Minute Massage $80

I (Name)_____, understand I am responsible for payment of services.

Signature _____ Date _____

PARENTS/LEGAL GUARDIANS: I understand that I am directly and fully responsible to Vibrant Life Center for all fees associated with chiropractic care my child/dependent receives. I understand that I am directly and fully responsible for making healthcare decisions for my child/dependent. The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration, I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child/legal dependent for whom I have the legal right to select and authorize health care services on behalf of.

☐ Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to select and authorize this care should change in any way, I will immediately notify this office.

_____ _____

Patient's Name Parent/Legal Guardian Name

_____ _____

Parent/Legal Guardian Signature Date