Natural Living Chiropractic
Natural Living For Life

Notice of Privacy

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Natural Living Chiropractic, LLC or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature _____ Date _____

Print Patient's Full Name _____ Time _____

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YOUR APPOINTMENTS

Dear Patient,

All disorders or conditions have what is referred to as “momentum”. This means that once a condition develops and progresses it will gain speed and become more serious as it continues. Treatments are custom developed for overcoming this momentum and correcting the original cause of the disorder for each person, individually.

For results to be obtained in the least possible time, it is asked that patients maintain a regular appointment schedule for the first few weeks. It is the patient’s responsibility to schedule appointments.

Sincerely,

Dr. Amber Trice
drambertrice@gmail.com
952-239-4457

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Treatment Guideline

Please read carefully as the details of patient procedures have changed:

Trying to provide the best care for you in this new COVID world, I have created a new office inside the garage. The entrance is located to the left of the garage. You will see a door on the side of the garage, that is where you will enter. Please text me when you have arrived, and I will let you know when to come in. You can park your car to the left of the garage where the flat cement pad is. If you happen to see a vehicle parked there, please wait in your car until the vehicle has left, then you can proceed to park in the designated spot.

I will be providing hand sanitizer for you to use upon your arrival and departure. I will also be providing masks for patients to utilize during their treatment unless you have a personal mask that you would prefer to use.

I will also ask that you use the restroom prior to your appointment. While a restroom is always available to you at any time during your appointment, it will require you to be inside the house.

For now, appointments need to be as brief as they can be in effort to avoid exposure and provide me with adequate cleaning time between patients. I will work as diligently as possible to address your physical needs, if you have more than one concern, it may require additional appointments.

Thank you for your cooperation,

Dr. Amber Trice
drambertrice@gmail.com
952-239-4457

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NEW PATIENT INTAKE FORM

Name: _____ Date:_____ DOB:_____

Address: _____City_____State_____Zip_____

Phone #:_____ Email:_____

Describe your current symptoms: _____

_____

Do you recall what caused the symptoms to start? _____

_____

How often do you experience your symptoms?

❍ Constantly ❍ Frequently ❍ Occasionally ❍ Intermittently

How are your symptoms changing?

❍ Getting Better ❍ Not Changing ❍ Getting Worse

How would you describe your symptoms?

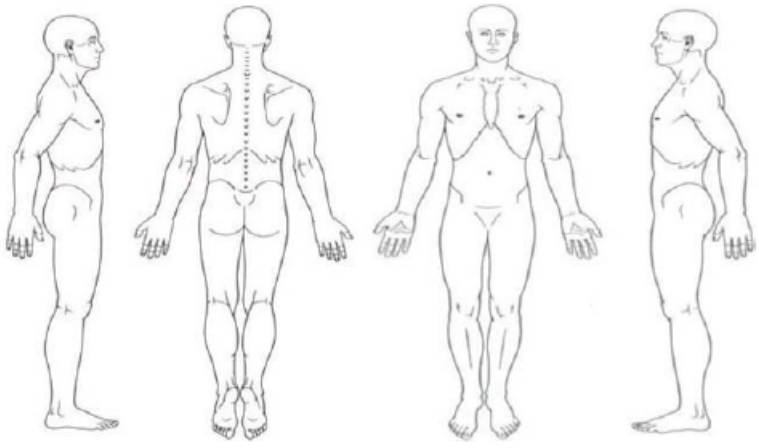
❍ Sharp ❍Shooting ❍ Dull Ache ❍ Burning ❍Tingling ❍Numb

How do your symptoms affect your ability to perform daily activities?

❍ No Complaints ❍ Mild (forgotten with activity) ❍ Moderate (pain Interferes, but does not limit activity)

❍Limits Activity ❍ Intense (preoccupied with obtaining relief) ❍ Severe (activity not possible)

Please draw on the below diagram the location of your symptoms:



Have you had any changes in your health since your last visit? ❍ No ❍Yes

If yes, please explain: _____

_____

Are you taking any medications or supplements? ❍ No ❍Yes

If yes, please list:_____

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NEW PATIENT INTAKE FORM

Please read thoroughly, initial at each applicable section and sign at the bottom. Thank You.

Personal Information

_____ I understand that my information may be used for internal marketing purposes (birthday coupons, newsletters, etc.). Personal information will not be shared with any other company for marketing purposes.

Information about Possible Risk of Chiropractic Treatment

_____ You have the right, as a patient, to be informed about your condition and the recommended integrative and complementary procedure to be used so that you make an informed decision whether or not to undergo the procedure after knowing the risks and hazard involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure. Doctors of chiropractic, Medical Doctors and Physical Therapists using manual therapy treatment for patients with headaches and cervical spine (neck) complaints are required to explain that there have been rare cases of injury to a vertebral artery as a result of treatment. Such an injury has been known to cause a stroke, sometimes with serious neurological damage. The rare chance of this happening is estimated to be approximately from 1 per 400,000 treatments to 1 per 10 million treatments. Appropriate tests will be performed to help identify if you may be susceptible to this type of injury; you will be notified if that is the case. If you have any questions about this, please do not hesitate to speak with your practitioner. As with any health procedure, complications may arise during treatment. These complications include soreness, muscle or ligament strain, dislocations, fractures, disc injuries or physiotherapy burns. These are extremely rare occurrences.

Consent for Treatment

_____ I authorize the performance of diagnostic tests, procedures and treatment deemed necessary by personnel involved in my care.

Assignment of Benefits

_____ Natural Living Chiropractic does not bill secondary insurance. We can provide you with the necessary documentation for you to submit to your insurance provider.

Guarantee of Payment

_____ I guarantee payment of all charges incurred for treatment in accordance with the rates and terms of this health care facility, despite insurance coverage or reimbursement.

Cancellation Policy

_____ I am aware that there is a 24 hour cancelation policy and if I cancel within the 24 hour period, I may be charged a $40 fee.

_____

Signature of Patient or Responsible Party **Date** **Relationship to Patient**

Authorization to Treat a Minor (under the age of 18)

_____I hereby request and authorize my doctor at this clinic to perform diagnostic tests and render chiropractic adjustment and treatment to my minor son/daughter. As of this date, I have legal right to select and authorize health care services for the minor child named above. Under the terms and conditions of my divorce (if applicable), separation or other authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in anyway, I will immediately notify Natural Living Chiropractic. 7

_____

Signature of Patient or Responsible Party **Date** **Relationship to Patient**

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Health Screening Questionnaire

In order to ensure the safety and health of everyone, it is important that you answer the following question. I sincerely appreciate your cooperation in doing your part to reduce risk of transmission.

Do you currently have, or have you had in the past 2 weeks any of the following?

Fever	□ Yes	□ No
Cough (productive or non-productive)	□ Yes	□ No
Bronchitis or Respiratory infection	□ Yes	□ No
Sore Throat	□ Yes	□ No
Allergy symptoms	□ Yes	□ No
Shortness of breath	□ Yes	□ No
Digestive Complaints, including vomiting or diarrhea	□ Yes	□ No
Severe Fatigue not associated with travel, myalgia and/or arthralgia	□ Yes	□ No
Have currently, or in the past 2 weeks, any symptoms of COVID-19?	□ Yes	□ No
Are you waiting to be tested for COVID-19?	□ Yes	□ No
Are you waiting for test results for COVID-19?	□ Yes	□ No
Have you tested positive for COVID-19?	□ Yes	□ No
Have you traveled on an airplane in the past 2 weeks?	□ Yes	□ No
Are you feeling ill?	□ Yes	□ No
If you answered YES to any of the questions above, please describe to what effect and how your symptoms have affected your daily activities.	□ Yes	□ No
Have you been following the MN Safe at Home guidelines?	□ Yes	□ No
What are your current risks of exposure to COVID-19? What current precautions have you been taking to reduce your exposure?		
Have you been present in an area of known community transmission? Or in close contact with a diagnosed patient or person under investigation of COVID-19?		

I have answered these questions truthfully and to the best of my ability:

_____

Signature of Patient or Responsible Party **Date** **Relationship to Patient**

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Detoxification Questionnaire

Name:_____ **Date:** _____/____/_____

Please read the following symptoms and rate them based on how you have been feeling over the past 30 days. Fill in the blanks using the appropriate numbers on the key below.

KEY:
0 (or leave blank) = No, never, or almost never occurs
1 = Occasionally occurs, effect is not severe
2 = Occasionally occurs, effect is severe
3 = Frequently occurs, effect is not severe
4 = Frequently occurs, effect is severe

Gastrointestinal
_____ Belching or gas
_____ Heartburn or acid reflux
_____ Bloating or abdominal discomfort shortly after eating
_____ Bad breath (halitosis)
_____ Aggravated by certain foods
_____ Diarrhea, chronic
_____ Undigested food in stool
_____ Constipation
_____ Nausea or vomiting
_____ Fewer than one bowel movement a day
_____ Stools are loose and unformed
_____ **TOTAL**

Liver
_____ Wine makes you sick
_____ Easily intoxicated if drinking alcohol
_____ Hangovers after drinking alcohol
_____ Sensitive to chemicals (perfume, solvents, exhaust)
_____ Sensitive to tobacco smoke
_____ Hemorrhoids or varicose veins
_____ Bothered by aspartame (NutraSweet)
_____ Chronic fatigue or Fibromyalgia
_____ Feeling wired or jittery if drinking coffee
_____ Feet have a strong odor
_____ Sweat has a strong odor
_____ **TOTAL**

Skin
_____ Experience hives, cysts, boils, rashes
_____ Cold sores, fever blisters, or herpes lesions
_____ Dry flaky skin and/or dandruff
_____ Fragile skin, easily chaffed, as in shaving
_____ Acne
_____ Itchy skin / dermatitis
_____ Dull colored skin, yellowish, pale or grayish
_____ Pale complexion
_____ Skin has a sour or unpleasant odor
_____ **TOTAL**

Eyes
_____ Dark circles around the eyes
_____ Puffy eyelids
_____ Bags under the eyes
_____ Bloodshot or reddened eyes
_____ Whites of eyes are yellowed
_____ Inflamed eyelids
_____ Eyes are water and/or itchy
_____ Blurred or tunnel vision
_____ **TOTAL**

Nails
_____ Ridged nails
_____ Splitting nails
_____ White spots on nails
_____ Crumbling nails
_____ **TOTAL**

Ears
_____ Ear infections
_____ Ear drainage or discharge
_____ Itchy ears
_____ Ringing in the ears
_____ **TOTAL**

Nose
_____ Stuffy nose
_____ Airborne allergies
_____ Sinus congestion, "stuffy head", sinus infections
_____ Runny or drippy nose
_____ **TOTAL**

Head
_____ Tension headaches at base of skull
_____ Splitting type headache
_____ Dizziness
_____ Faintness
_____ **TOTAL**

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Detoxification Questionnaire

Mouth and Throat
_____ Coated tongue (yellow, grayish-white or thick film)
_____ Swollen tongue
_____ Hoarseness
_____ Difficulty swallowing
_____ Lump in throat
_____ Dry mouth, eyes and / or nose
_____ Gag easily or need to clear throat often
_____ Mouth ulcers or canker sores
_____ **TOTAL**

Heart/Lungs
_____ Asthma
_____ Wheezing or difficulty breathing
_____ Shortness of breath
_____ Chest congestion
_____ Heart races, rapid heartbeat
_____ Fast pulse at rest
_____ Flush or blush easily or face turns red for no reason
_____ Heart skips beats
_____ **TOTAL**

Mental Emotional
_____ Feel 'foggy', thinking seems slow or fuzzy
_____ Bizarre vivid or nightmarish dreams
_____ Depressed
_____ Worried, apprehensive, anxious
_____ Nervous or agitated
_____ Mentally sluggish, reduced initiative
_____ Difficulty concentrating
_____ Mood swings
_____ Coordination is poor
_____ Poor memory
_____ **TOTAL**

Musculoskeletal
_____ Pain or swelling in joints
_____ Muscles become easily fatigued
_____ Muscle aches and pains
_____ Arthritic tendencies
_____ Joints are painful upon waking
_____ Joint pain after mild exertion
_____ Joint pain experienced after eating certain foods
_____ Abdomen tends to hang out
_____ Surface of abdomen is uneven and distended
_____ Use over-the-counter pain medications
_____ **TOTAL**

Metabolism
_____ Pulse speeds after eating
_____ Night sweats
_____ MSG sensitivity
_____ Mood swings associated with periods (PMS)
_____ Breast tenderness associated with cycle
_____ **TOTAL**

Energy Levels
_____ Weakness
_____ Easily fatigued, sleepy during the day
_____ Fatigue is persistent and extreme
_____ Apathetic and lethargic
_____ Tired, in spite of a good night of rest
_____ **TOTAL**

Weight
_____ Crave bread or noodles
_____ Crave certain foods
_____ Retaining water
_____ Excessive weight
_____ **TOTAL**

Kidney
_____ Urine has a strong odor
_____ Pain in mid back region
_____ Urine is frothy
_____ Urinate infrequently
_____ **TOTAL**

Immune System
_____ Frequent infections (bladder, skin, ear, chest, sinus)
_____ Frequent colds or flu
_____ **TOTAL**

Other
_____ Food allergies
_____ Feel worse in moldy or musty place
_____ **TOTAL**

Please add the numbers from each section and write the total in the space provided under that section. Then add all the totals for each section together and put that total in the space below.

GRAND TOTAL _____