Optimized Wellness and Nutrition Center

Dba: Community Chiropractic

INFORMED CONSENT FORM & TERMS FOR NUTRITIONAL COUNSELING*

I, _____, give consent to Community Chiropractic to provide nutrition counseling to me or to the client for which I am legally responsible. The consultation will provide information and guidance about health factors within my own control: my diet, nutrition, and lifestyle.

I understand that Dr. William Jackson is a chiropractor – not a medical physician – and does not dispense medical advice, nor will he diagnose or treat any medical condition, but will provide nutritional support and nutrition education for an already diagnosed or suspected condition. He provides education to enhance my knowledge of health through the use of whole foods, dietary supplements, and vitamins.

Methods of nutritional evaluation or testing made available to me are not intended to diagnose disease. Rather, these assessment tests and/or blood labwork are intended as a guide toward developing an appropriate health-supportive program for me, and to monitor my progress in achieving my goals.

Personal information and history divulged in session to Community Chiropractic will be kept confidential, unless I consent to sharing my information.

I agree to hold Community Chiropractic [Dr. William Jackson] harmless for claims or damages in connection with our work together. This is a contract between Community Chiropractic, and me, and I understand that it is also a release of potential liability.

OWN your health,

Dr. Jackson

_____

Client or Guardian's Signature Date

_____

Print Name (s)

*This statement has not been evaluated by the Food and Drug Administration. This product is not intended to diagnose, treat, cure, or prevent any disease.

CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

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

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4 ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) _____

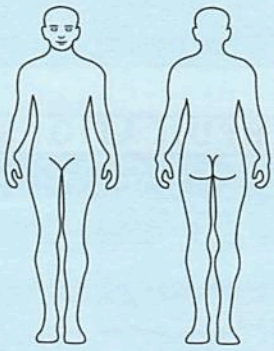
5 PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

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ASSIGNMENT OF PROCEEDS, LIEN, AND AUTHORIZATION

I hereby authorize and direct any and all insurance carriers, attorneys, agencies, governmental department companies, individuals, and/or other legal entities (payer), which may elect or be obligated to pay, provide, or distribute benefits to me for any medical conditions, accidents, injuries, or illness, past, present, or future ("condition") to pay directly and exclusive to Community Chiropractic such sums as may be owing to Community Chiropractic for charges incurred by me at the office relating to my condition (charges), with such payments to be made exclusively in the office of Community Chiropractic. I further grant a lien to Community Chiropractic with respect to my charges. This lien shall apply to all payers and to the full extent permitted by law. For the purposes of this document (herein, "Assignment and Lien"), "benefits" shall include, but not be limited to, proceeds from any settlement, judgment, or verdict, as well as any proceeds relating to commercial health or group insurance, medical payments benefits, personal injury protection, or no-fault coverage, uninsured and underinsured motorist coverage, third-party liability distributions, disability benefits, worker's compensation benefits, and any other benefits or proceeds payable to me for the purposes stated herein.

I authorize this Office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Assignment and Lien. I further authorize and direct all payers to release to Community Chiropractic any information regarding any coverage or benefits which I may have including, but not limited to, at the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims. I hereby direct this Office to file a copy of this Assignment and Lien, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby grant Community Chiropractic power of attorney to endorse/sign any name to any and all checks listing me as a payee which are presented to this Office for payment of an account relating to me, my spouse, or any of my dependents. I further authorize Community Chiropractic to apply any credit balances on charges incurred by me to any other outstanding charges still owed by me, my spouse, or my dependents regardless of whether these other charges are related to my condition.

I understand that I remain personally responsible for the total amounts due Community Chiropractic for services. I further understand that until my insurance has been verified by Community Chiropractic all charges for services are to be paid in full at the time the service is rendered. This Assignment and Lien does not constitute any consideration for this Office to await payments and it may demand payments from me immediately upon rendering services at its option. If this Office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse Community Chiropractic for all costs of such collection efforts, including, but not limited to, all court costs and all attorney fees.

This Assignment and Lien shall not be modified or revoked without the mutual written consent of Community Chiropractic and myself. I hereby revoke any previously signed authorization, whether executed at this office or any other office to the extent that the terms of those authorizations conflict with the terms of this Assignment and Lien.

Patient Name (Please print)_____

Patient Signature_____ Date_____

Name of Custodial Parent or Legal Guardian_____

Parent/Guardian's Signature_____ Date_____

Witness_____ Date_____

William J. Jackson, D.C.
260 Hwy. 70 W. ♦ Garner, NC 27529 ♦ 919.662.0044 ♦ Fax: 919.662.1650
www.mygarnerchiropractor.com

INSTRUCTIONS TO COUNSEL

I, _____ clearly understand that all past, present and future bills incurred at Community Chiropractic clinic, are my responsibility for payment.

I hereby ratify my agreement to pay all bills incurred during my health care at this clinic.

I also, hereby irrevocably agree to have the doctor's entire bill paid from any proceeds of any nature by way of settlement, judgement or otherwise I or you might receive. I do hereby irrevocably instruct you _____ to pay the doctor in full from any such proceeds of settlement, judgement or enforcement of judgement actions. You are to pay the doctor prior to disbursing any proceeds to me.

I also understand that if the settlement does not cover the doctor's entire bill, I am still responsible for the remainder.

I do hereby waive any applicable statute of limitations on the collection of my account with this clinic.

I instruct you, _____, not to attempt to negotiate my doctor's bill, who has provided all services billed for, and I agree to pay in full.

_____ _____
Signature Date

_____ _____
Witness Date

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To Order Call: 1-800-950-8044

#130-0720

Name _____ Date _____

Height _____ Weight _____ BP ____/____ Pulse _____ Respiration _____

Cervical Motion

Flexion 5/50 _____
Extension 5/60 _____
R Lat Flex 5/45 _____
L Lat Flex 5/45 _____
R Rotation 5/80 _____
L Rotation 5/80 _____

Thoraco / Lumbar

Flexion 5/90 _____
Extension 5/30 _____
R Lat Flex 5/30 _____
L Lat Flex 5/30 _____
R Rotation 5/30 _____
L Rotation 5/30 _____

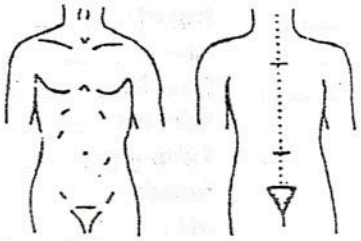
Deep Tendon Reflexes

Biceps _____
Triceps _____
Patellar _____
Achilles _____

Valsalva's _____
C. Comp _____
M. C. Comp _____
Shld. Depr _____
Distraction _____
Soto-Hall _____

Kemp's _____
Laseque's _____
Braggard's _____
Fabere _____
D. Leg Raise _____
Bechterew's _____
Nachlas (Ely) _____
Yeoman's _____
Hibb's _____

Localization



Name _____ Date _____

Height _____ Weight _____ BP ____/____ Pulse _____ Respiration _____

Cervical Motion

Flexion 5/50 _____
Extension 5/60 _____
R Lat Flex 5/45 _____
L Lat Flex 5/45 _____
R Rotation 5/80 _____
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Thoraco / Lumbar

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Extension 5/30 _____
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L Lat Flex 5/30 _____
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Kemp's _____
Laseque's _____
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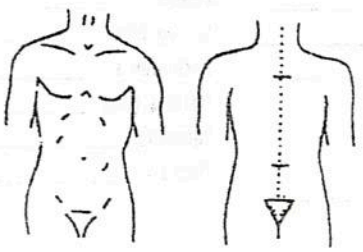
Localization



NAME: DATE:

COMPLAINT:	HEAD		
LOCATION:			
CHARACTER:	☐ DULL ☐ BURNING	☐ SHARP ☐ NUMB	☐ RADIATING ☐ TINGLE
FREQUENCY:	☐ CONSTANT	☐ INTERMITTENT	
DURATION:	____ HOURS ____ DAYS ____ WEEKS ____ MONTHS ____ YEARS		
COMPLAINT:	NECK / SHOULDER / UPPER ARM / ELBOW / LOWER ARM / WRIST / FINGERS		
LOCATION:			
CHARACTER:	☐ DULL ☐ BURNING	☐ SHARP ☐ NUMB	☐ RADIATING ☐ TINGLE
FREQUENCY:	☐ CONSTANT	☐ INTERMITTENT	
DURATION:	____ HOURS ____ DAYS ____ WEEKS ____ MONTHS ____ YEARS		
COMPLAINT:	CHEST / STOMACH / INTESTINAL / FEMALE__ MALE__ ORGANS		
LOCATION:			
CHARACTER:	☐ DULL ☐ BURNING	☐ SHARP ☐ NUMB	☐ RADIATING ☐ TINGLE
FREQUENCY:	☐ CONSTANT	☐ INTERMITTENT	
DURATION:	____ HOURS ____ DAYS ____ WEEKS ____ MONTHS ____ YEARS		
COMPLAINT:	MID BACK / LOWER BACK / UPPER LEG / KNEE / LOWER LEG / ANKLE / FOOT /		
LOCATION:			
CHARACTER:	☐ DULL ☐ BURNING	☐ SHARP ☐ NUMB	☐ RADIATING ☐ TINGLE
FREQUENCY:	☐ CONSTANT	☐ INTERMITTENT	
DURATION:	____ HOURS ____ DAYS ____ WEEKS ____ MONTHS ____ YEARS		

STRESS SYMPTOMS		
HEADACHE	YES	NO
VERTIGO WITH/WITHOUT FAINTING	YES	NO
BLURRED VISION	YES	NO
LOSS OF MEMORY OR CONCENTRATION	YES	NO
DEPRESSION AND CRYING SPELLS	YES	NO
LOSS OF ENERGY	YES	NO
LOSS OF SLEEP	YES	NO
BUZZING OR RINGING IN THE EARS	YES	NO
LOW RESISTANCE - COLDS THAT LINGER	YES	NO

COMMENTS:

KEY: S= subjective; O= objective - ... eas of intersegmental joint dysfunction or spinal k... gy, or are areas of muscle tightness, spasm, tenderness, and/or trigger po... ent; P= procedure/plan - CMT= chiropractic ma... erapy, MR/TPT= myofascial release or trigger point therapy, Ph-ther=physiologic therapeutics; Post-Assessment - TW=treatment Tolerated Well by patient.

Patient Name: ______________________

S: Patient reports

Date __________

O/P: CMT to below:
1C__2C__3C__4C__5C__6C__7C__
1T__2T__3T__4T__5T__6T__7T__8T__9T__10T__11T__12T__
1L__2L__3L__4L__5L__ Rt.SI__ Lt.SI__ Other:
P: ( )Same as/See notes on: **P/Comments:**
Post-Assess.: **Sched.:** **A/Comments:**

MR or TPT to below:
suboccipital____ cervical_______ trap./levators___
rot. cuff____ thoracic_______ other
hip flexors____ lumbar______ hip rotators___
Ph-ther: See travel card

S: Patient reports

Date __________

O/P: CMT to below:
1C__2C__3C__4C__5C__6C__7C__
1T__2T__3T__4T__5T__6T__7T__8T__9T__10T__11T__12T__
1L__2L__3L__4L__5L__ Rt.SI__ Lt.SI__ Other:
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1C__2C__3C__4C__5C__6C__7C__
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S: Patient reports

Date __________

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1C__2C__3C__4C__5C__6C__7C__
1T__2T__3T__4T__5T__6T__7T__8T__9T__10T__11T__12T__
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1L__2L__3L__4L__5L__ Rt.SI__ Lt.SI__ Other:
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Post-Assess.: **Sched.:** **A/Comments:**

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hip flexors____ lumbar______ hip rotators___
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Date __________

O/P: CMT to below:
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1T__2T__3T__4T__5T__6T__7T__8T__9T__10T__11T__12T__
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1L__2L__3L__4L__5L__ Rt.SI__ Lt.SI__ Other:
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Post-Assess.: **Sched.:** **A/Comments:**

MR or TPT to below:
suboccipital____ cervical_______ trap./levators___
rot. cuff____ thoracic_______ other
hip flexors____ lumbar______ hip rotators___
Ph-ther: See travel card

PATIENT NAME _____

PAYMENT AGREEMENT

FOR VALUE RECEIVED, the undersigned promises to pay to Community Chiropractic Clinic all balances due on this account from the date if first treatment to the date of last treatment.

The undersigned further agrees that a service charge of one and one-half percent (1 ½ %) per month on any unpaid balance shall be added to any outstanding balance remaining unpaid after thirty days from date of treatment, and the undersigned further agrees to pay all costs of collections of any such balance, including reasonable attorney's fees.

DATE: _____

_____
Patient Signature

ADDRESS: _____

_____

WITNESS: _____

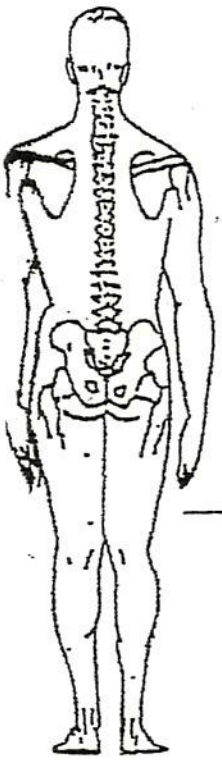
William J. Jackson, D.C.
260 Hwy. 70 W. ♦ Garner, NC 27529 ♦ 919.662.0044 ♦ Fax: 919.662.1650
www.mygarnerchiropractor.com

Name _____ Date _____ File _____

Date of onset:

)ates of similar symptoms: Course: S B W

:ondition is related to patient's: ( ) Work; ( ) Auto; ( ) other accident



1. Onset: (how)

Medical treatment or diagnos

Results?:

Previous History:

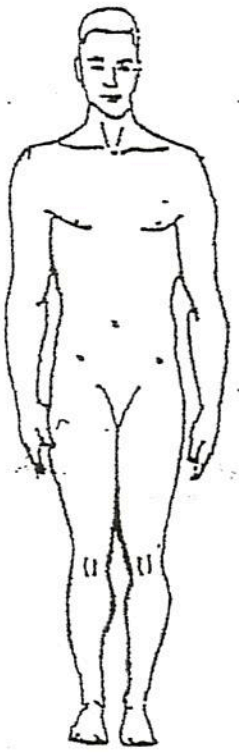
Anything Helped?:

2. Onset: (how)

Medical treatment or diagnos

Results?:

Previous History:



3.

Complications

Surgeries

History of Accidents

D.C. History

Any activities limits

Medications (presently takin

Name _____ Date _____

Height _____ Weight _____ BP _____/_____ Pulse _____ Respiration _____

Cervical Motion

Flexion 5/50 _____
Extension 5/60 _____
R Lat Flex 5/45 _____
L Lat Flex 5/45 _____
R Rotation 5/80 _____
L Rotation 5/80 _____

Thoraco / Lumbar

Flexion 5/90 _____
Extension 5/30 _____
R Lat Flex 5/30 _____
L Lat Flex 5/30 _____
R Rotation 5/30 _____
L Rotation 5/30 _____

Deep Tendon Reflexes

Biceps _____
Triceps _____
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Achilles _____

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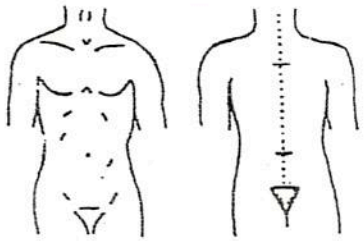
C. Comp _____
M. C. Comp _____
Shld. Depr _____
Distraction _____
Soto-Hall _____

Kemp's _____
Laseque's _____
Braggard's _____
Fabere _____
D. Leg Raise _____
Bechterew's _____
Nachlas (Ely) _____
Yeoman's _____
Hibb's _____

Localization



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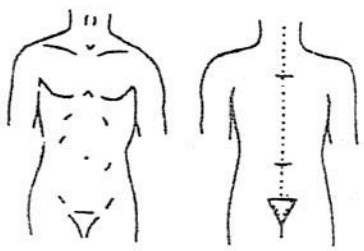
Localization



Optimized Wellness and Nutrition Center

Dba: Community Chiropractic

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Personal information and history divulged in session to Community Chiropractic will be kept confidential, unless I consent to sharing my information.

I agree to hold Community Chiropractic [Dr. William Jackson] harmless for claims or damages in connection with our work together. This is a contract between Community Chiropractic, and me, and I understand that it is also a release of potential liability.

OWN your health,

Dr. Jackson

_____

Client or Guardian's Signature Date

_____

Print Name (s)

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