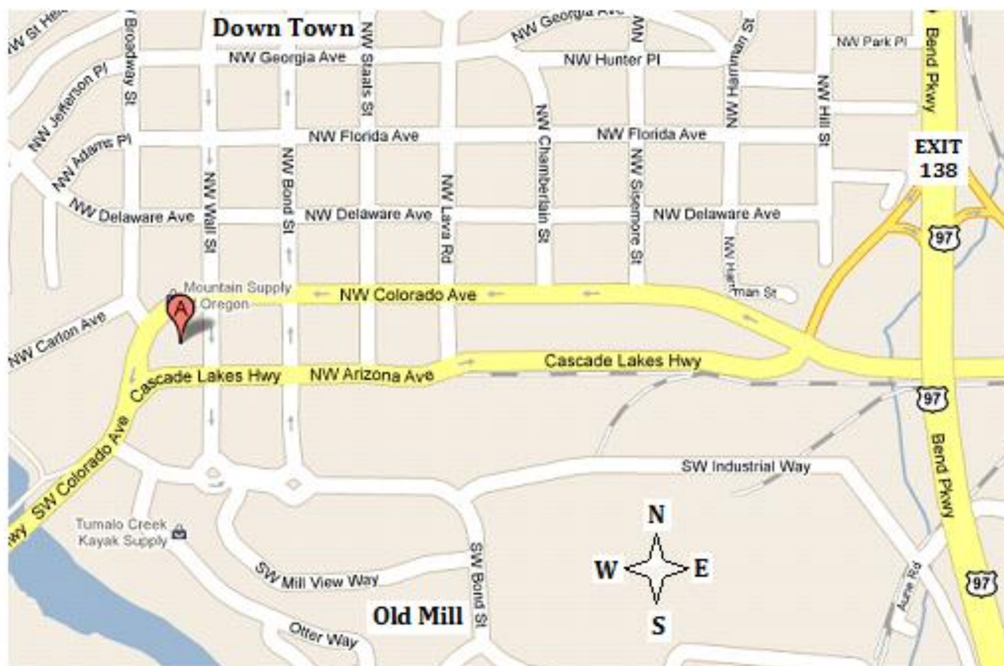
FALLING WATERS

INJURY & HEALTH MANAGEMENT CENTER

APPOINTMENT CHECKLIST

- ❒ **ARRIVAL TIME**:
  Please ensure that you come to your appointment at your scheduled arrival time. If needing to reschedule, please contact the office no less than 24 hours prior to your scheduled appointment.
- ❒ **PAPERWORK**:
  Please have this packet completed prior to arriving for your appointment. If not completed, please arrive 25 minutes prior to your scheduled arrival time.
- ❒ **UNDER 18 YEARS OF AGE**:
  If patient is under 18 years old, parental signatures are required on all paperwork.
- ❒ **REFERRAL / PRESCRIPTION**:
  If you are being referred to our office by another doctor or practitioner, please bring the referral or prescription with you to your appointment.
- ❒ **INSURANCE CARD AND DRIVER'S LICENSE**:
  Please ensure you bring these cards with you to your appointment as we will need copies for our records.

AREA MAP



Please print the "**DIRECTIONS TO FALLING WATERS**" page from our website for more specific directions on how to locate our clinic, or if using a GPS, enter the address below.

GENERAL INTAKE

Remember to bring Completed Paperwork. (If paperwork is not completed, arrive 25 min prior to appt.)

First Name: ________________________ MI: _______ Last Name: ________________________ SS#: ___________________

Mailing Address: ____ City: _________________ State: ____ Zip: ___________

Home Phone: ________________________ Cell: ________________________ Email: __________________________________

Preferred Communication Type: ☐ Phone ☐ Text ☐ Email Preferred Language: __________________________________

Sex: ☐M ☐F DOB: ___/___/______ Age: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Do you have children: ☐ No ☐ Yes, if yes, how many children: _________ What are their ages: _______________________

Occupation: ____________________________ Employer: ______________________ Work Phone: ______________________

Emergency Contact Name: _________________________ Phone: _________________________ Relationship: _____________

Do you give permission for our office to update your general medical practitioner with the progress of your condition? Yes No

Name of Medical Doctor: __________________________ Who may we thank for referring you to us? _____________________

In compliance with the governmental EHR incentive program and CMS requirements, we ask the following:

Race (select one): ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Pacific Islander ☐ White (Caucasian) ☐ Other ☐ I Decline to Answer

Ethnicity (select one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ I Decline to Answer

RESPONSIBLE PARTY INFORMATION

If you are the responsible party, mark "self" and move down to "Payment Information."

Person responsible for patient's charges: ☐ Self ☐ Spouse ☐ Parent ☐ Other: __________________

First Name: _______________________ MI: _________ Last Name: _______________________ SS#: ____________________

Street Address: _________________________________ City: ___________________ State: _______ Zip: _________________

Sex: ☐ M ☐ F DOB: ___/___/______ Age: _____ Cell: _______________________ Work Phone: _______________________

Employer: ____________________________________ Occupation: ____

PAYMENT INFORMATION

Please check the following payment methods that apply: ☐ Health Insurance ☐ Time of Service (Cash)

☐ This injury is related to a Work Injury ☐ This injury is related to an auto accident Date of Injury/Accident: ___/___/______

ASSIGNMENT AND RELEASE

Scheduling an appointment reserves this time especially for you and no one else. Therefore, our office requires **24 hours notice to cancel an appointment**. **If 24 hours is not given, a charge of $20** will be billed to your account.

I ____________________ clearly **understand and agree that all services provided will be charged directly to me and that I am personally responsible for payment**. I agree to allow Falling Waters, LLC and/or provider to bill my insurance company as a courtesy and permit the release of medical records necessary to process my claims. I authorize Falling Waters, LLC to initiate a complaint to the Insurance Commissioner for any reason on my behalf. I authorize payments to be made directly to Falling Waters, LLC and/or provider for treatment rendered. **I understand that co-payments and time of service fees are due at the time of service, I may receive an additional bill for services not covered by my insurance and any fees incurred by sending to collections will be added.**

Patient's Signature: ____ **Date:** ____________________________________
Parent or guardian signature needed if patient under 18 *mm / dd / yyyy*

WELCOME TO FALLING WATERS

WHAT IS YOUR DESIRED APPROACH TO CARE? *(Please choose all that apply)*

- ❒ **TRADITIONAL (ALLOPATHIC) MEDICINE:** A system of medical practice that aims to combat symptoms, conditions and diseases by the use of remedies such as drugs or surgery.
- ❒ **FUNCTIONAL MEDICINE:** Involves understanding the origins, treatment and/or prevention of symptoms, conditions and diseases. Special laboratory evaluation is often considered to help diagnose and guide treatment, which focuses on diet modification, nutritional recommendations, prescribed supplementation and limited use of medications when necessary.
- ❒ **PHYSICAL MEDICINE:** An orthopedic approach to care, emphasizing range of motion, flexibility, strength, core stability, posture and ergonomics, with the goals of improving functional ability and minimizing recurrence. Treatment usually involves both passive care (joint manipulation/mobilization, traction, laser therapy, stretching and massage therapy performed by providers) and active care (in-office rehabilitation and independent home exercises done by the patient).
- ❒ **UNSURE or MULTIPLE** (would like provider's opinion and/or to discuss further)

WHAT ARE YOUR GOALS FOR CARE? *(Please choose all that apply)*

People seek help from professional healthcare providers for many reasons. Please check the appropriate boxes for the goal(s) you are interested in or would like to achieve:

General Goals:

- ❒ **RELIEF CARE:** Focused on symptomatic relief of pain, discomfort or other symptoms.
- ❒ **CURATIVE / REHABILITATIVE CARE**: For those interested in understanding the underlying cause(s) of their symptoms employing strategies that focus on restoration of function to work towards creating an environment where injury or illness is less likely to reoccur.
- ❒ **MAINTENANCE / PREVENTIVE CARE:** Geared towards those who wish to maintain their current state of health by having regular follow-up appointments. (e.g. periodic check-ups/treatments, yearly physicals, men's & women's health exams, laboratory testing, etc.)
- ❒ Would like the **PROVIDER TO SELECT** the type of care appropriate for my condition.

Specific Goals:

❒ ↑ Strength / Endurance	❒ ↑ Energy	❒ Injury Rehab: ______________	❒ Reduce medication use
❒ ↑ Flexibility	❒ ↑ Balance	❒ Sport Specific: _____________	❒ Other: ______________
❒ ↓ Pain	❒ Feel Better	❒ ↓ Weight: ______lbs	________________________
❒ ↓ Stress	❒ Sleep Better	❒ Achieve ideal weight: _____lbs	________________________

Specific Activities:

If applicable, please list 3-4 **specific activities** you are not able to perform as well as you'd like, due to your current complaint(s). Then rate your current ability for each activity on a scale from 0 to 10 where **0 is completely unable**, and **10 is fully able**:

1) ______________________________________ (___ /10) **3)** ______________________________________ (___ /10)

2) ______________________________________ (___ /10) **4)** ______________________________________ (___ /10)

READINESS ASSESSMENT

Please rate on a scale of **0** *(not willing)* to **5** *(very willing)*, your **willingness** to:

- Significantly modify your diet: 0 1 2 3 4 5
- Take nutritional supplements daily: 0 1 2 3 4 5
- Engage in regular exercise: 0 1 2 3 4 5
- Modify your lifestyle: 0 1 2 3 4 5
- Practice relaxation techniques: 0 1 2 3 4 5
- Have periodic lab tests to assess progress: 0 1 2 3 4 5

PRIMARY CARE STATUS

Do you currently have a **primary care physician**? **YES** **NO**

If Yes, who? ____

If No, are you interested in receiving your primary care at Falling Waters? **YES** **NO**

CHIEF COMPLAINT FORM

Please list and describe your complaints/concerns below, in order of their severity, starting with the most severe.

#1 Problem: ______________________________

When did it start? ____________________ How often does it bother you? ____________________

How has it changed? *(improved or worsened with time)* ____________________

How severe is it from 0 *(none)* to 10 *(worst imaginable)*? ____________________

What makes it worse? ____________________ Better? ____________________

Please list any other symptoms you feel are related to this complaint: ____________________

Have you had any other treatment for this? **YES NO**

If yes, please complete the following table:

Provider	Date seen	Diagnostic testing	Diagnosis	Treatment	Response
1)					
2)					
3)					

#2 Problem: ______________________________

When did it start? ____________________ How often does it bother you? ____________________

How has it changed? *(improved or worsened with time)* ____________________

How severe is it from 0 *(none)* to 10 *(worst imaginable)*? ____________________

What makes it worse? ____________________ Better? ____________________

Please list any other symptoms you feel are related to this complaint: ____________________

Have you had any other treatment for this? **YES NO**

If yes, please complete the following table:

Provider	Date seen	Diagnostic testing	Diagnosis	Treatment	Response
1)					
2)					
3)					

#3 Problem: ______________________________

When did it start? ____________________ How often does it bother you? ____________________

How has it changed? *(improved or worsened with time)* ____________________

How severe is it from 0 *(none)* to 10 *(worst imaginable)*? ____________________

What makes it worse? ____________________ Better? ____________________

Please list any other symptoms you feel are related to this complaint: ____________________

Have you had any other treatment for this? **YES NO**

If yes, please complete the following table:

Provider	Date seen	Diagnostic testing	Diagnosis	Treatment	Response
1)					
2)					
3)					

#4 Problem: ______________________________

When did it start? ____________________ How often does it bother you? ____________________

How has it changed? *(improved or worsened with time)* ____________________

How severe is it from 0 *(none)* to 10 *(worst imaginable)*? ____________________

What makes it worse? ____________________ Better? ____________________

Please list any other symptoms you feel are related to this complaint: ____________________

Have you had any other treatment for this? **YES NO**

If yes, please complete the following table:

Provider	Date seen	Diagnostic testing	Diagnosis	Treatment	Response
1)					
2)					
3)					

REVIEW OF SYMPTOMS

1. CONSTITUTIONAL Please rate your overall level of health (compared to others in your age group)

1. Excellent
2. Very Good
3. Good
4. Fair
5. Poor
6. Other:_______________________

Please **circle YES** or **NO** for each of the symptom categories below, based on symptoms you've had in the **PAST 30 DAYS**.

If yes, please provide a **score** next to the individual symptom using the following point system:

1 = Occasionally have it, effect is NOT severe
2 = Occasionally have it, effect IS severe
3 = Frequently have it, effect is NOT severe
4 = Frequently have it, effect IS severe

2. GENERAL YES NO

Fever/sweats	1 2 3 4	Chills	1 2 3 4	Weight loss	1 2 3 4	Other: ____________________
Fatigue	1 2 3 4	Recent infections	1 2 3 4	Multiple joint pain	1 2 3 4	
Fainting	1 2 3 4	Recurrent infections	1 2 3 4	Swollen joints	1 2 3 4	**Provider Score:** _____

3. HEAD / JAW YES NO

Headaches	1 2 3 4	Faintness	1 2 3 4	Grind teeth at night	1 2 3 4	Other: ____________________
Migraines	1 2 3 4	Dizziness	1 2 3 4	Insomnia/sleep change	1 2 3 4	
Jaw pain	1 2 3 4	Unexplained hair loss	1 2 3 4			**Provider Score:** _____

4. EYES YES NO

Loss/change in vision	1 2 3 4	Glasses/contacts	1 2 3 4	Swollen, red or sticky eyelids	1 2 3 4	Excessive watering	1 2 3 4
Double vision	1 2 3 4	Flashing lights/halos	1 2 3 4			Other: ____________________	
Blurry/tunnel vision	1 2 3 4	Pain/sensitivity to light	1 2 3 4	Bags or dark circles under the eyes	1 2 3 4		
Floaters	1 2 3 4	Watery/itchy eyes	1 2 3 4			**Provider Score:** _____	

5. EARS – HEARING YES NO

Hearing loss/change	1 2 3 4	Itchy ears	1 2 3 4	Balance problems	1 2 3 4	Other: ____________________
Ringing/buzz in ears	1 2 3 4	Drainage from the ear	1 2 3 4			
Ear pain	1 2 3 4	Earaches/infections	1 2 3 4			**Provider Score:** _____

6. NOSE-MOUTH-THROAT YES NO

Changes in smell	1 2 3 4	Post-nasal drip	1 2 3 4	Excessive mucus formation	1 2 3 4	Sore throat/infection	1 2 3 4
Nose bleeds	1 2 3 4	Sinus problems	1 2 3 4			Gagging, need to clear throat	1 2 3 4
Nose pain	1 2 3 4	Sinus infections	1 2 3 4	Voice changes	1 2 3 4		
Hay fever	1 2 3 4	Changes in taste	1 2 3 4	Sore throat, hoarseness, loss of voice	1 2 3 4	Other: ____________________	
Sneezing attacks	1 2 3 4	Canker sores	1 2 3 4				
Colds	1 2 3 4	Swollen or discolored tongue, gums or lips	1 2 3 4	Trouble swallowing	1 2 3 4		
Stuffy nose	1 2 3 4			Chronic coughing	1 2 3 4	**Provider Score:** _____	

7. SKIN YES NO

Dry skin	1 2 3 4	Flushing	1 2 3 4	Excessive sweating	1 2 3 4	Other: ____________________
Skin lesions/rash	1 2 3 4	Dermatitis	1 2 3 4	Hives	1 2 3 4	
Pimples/acne	1 2 3 4	Infections	1 2 3 4	Hair loss	1 2 3 4	
Bruise easily	1 2 3 4	Warts	1 2 3 4			**Provider Score:** _____

8. CARDIOVASCULAR YES NO

Chest pain/angina	1 2 3 4	Irregular or skipped heart beat	1 2 3 4	Leg cramps while walking	1 2 3 4	Other: ____________________
Rapid or pounding heart rate	1 2 3 4					
		Leg or ankle swelling	1 2 3 4			
Cold fingers/toes	1 2 3 4	Leg cramps at night	1 2 3 4			**Provider Score:** _____

9. RESPIRATORY YES NO

Difficulty breathing	1 2 3 4	Chest congestion	1 2 3 4	Allergies	1 2 3 4	Other: ____________________
Shortness of breath	1 2 3 4	Cough/sputum	1 2 3 4	Asthma attacks	1 2 3 4	
Pain with breathing	1 2 3 4	Wheezing	1 2 3 4			**Provider Score:** _____

10. GASTROINTESINAL YES NO

Appetite/diet change	1 2 3 4	Heartburn/reflux	1 2 3 4	Bowel habit changes	1 2 3 4	Ulcers	1 2 3 4
Bloated feeling	1 2 3 4	Stomach pain	1 2 3 4	Hemorrhoids	1 2 3 4	Other: ____________________	
Constipation	1 2 3 4	Nausea/vomiting	1 2 3 4	Rectal bleeding	1 2 3 4		
Diarrhea	1 2 3 4	Belching or gas	1 2 3 4	Jaundice (yellowing)	1 2 3 4	**Provider Score:** ____	

11. JOINTS / MUSCLES YES NO

Pain/ache in joints	1 2 3 4	Popping or locking of joints	1 2 3 4	Joint swelling	1 2 3 4	Other: ____________________
Pain/ache in muscles	1 2 3 4	Giving way of joints	1 2 3 4	Feelings of weakness or tiredness	1 2 3 4	
Stiff/limited motion	1 2 3 4					**Provider Score:** _____

12. WEIGHT YES NO

Excessive weight	1 2 3 4	Compulsive eating	1 2 3 4	Craving certain foods	1 2 3 4	Other: ____________________
Underweight	1 2 3 4	Binge eating/drinking	1 2 3 4	Water retention	1 2 3 4	***Provider Score:*** _____

13. MIND YES NO

Personality changes	1 2 3 4	Difficulty making decisions	1 2 3 4	Stuttering or stammering	1 2 3 4	Other: ____________________
ADD/ADHD	1 2 3 4	Impulsiveness	1 2 3 4	Slurred speech	1 2 3 4	
Poor concentration	1 2 3 4	Poor memory	1 2 3 4	Poor physical coordination	1 2 3 4	
Confusion, poor comprehension	1 2 3 4	Learning disabilities	1 2 3 4			***Provider Score:*** _____

14. EMOTIONAL YES NO

Mood swings	1 2 3 4	Exhaustion	1 2 3 4	Anxiety, fear or nervousness	1 2 3 4	Abusive behavior	1 2 3 4
Short attention span	1 2 3 4	Impulsiveness	1 2 3 4	Nervous breakdown	1 2 3 4	Abuse drugs	1 2 3 4
Scattered thoughts	1 2 3 4	Feel blue	1 2 3 4	Anger, irritability, aggression	1 2 3 4	Abuse alcohol	1 2 3 4
Prone to stress	1 2 3 4	Frequent crying	1 2 3 4	Short tempered	1 2 3 4	Other: ____________________	
Difficulty sleeping	1 2 3 4	Prone to depression	1 2 3 4				
Poor dream recall	1 2 3 4	Depression	1 2 3 4			***Provider Score:*** _____	

15. NEUROLOGICAL YES NO

Numbness/tingling	1 2 3 4	Poor balance	1 2 3 4	Other: ____________________	
Weakness	1 2 3 4	Bowel/bladder changes	1 2 3 4		***Provider Score:*** _____

16. URINARY YES NO

Pain with urination	1 2 3 4	Trouble starting or stopping	1 2 3 4	Urinary tract infections	1 2 3 4	Other: ____________________
Frequent or urgent urination	1 2 3 4	Leakage	1 2 3 4	Smelly urine	1 2 3 4	
Nighttime urination	1 2 3 4	Urinary discharge	1 2 3 4	Blood in urine	1 2 3 4	
				Pus in urine	1 2 3 4	***Provider Score:*** _____

17. ENDOCRINE YES NO

High/low blood sugar	1 2 3 4	Hard to lose weight	1 2 3 4	Headaches	1 2 3 4	Other: ____________________
Weight gain/loss	1 2 3 4	Dry skin, hair, nails	1 2 3 4	Fatigue	1 2 3 4	
		Heat/cold intolerance	1 2 3 4			***Provider Score:*** _____

WOMEN ONLY

18. Do you have now or have had any of these symptoms in the last 3 months? YES NO

Menstrual cramps or problems	1 2 3 4	Sore breasts	1 2 3 4	Genital discharge/odor	1 2 3 4	Low libido	1 2 3 4
Irregular cycle	1 2 3 4	Abdominal/pelvic pain	1 2 3 4	Yeast infections or itchiness	1 2 3 4	Other: ____________________	
Irregular flow	1 2 3 4	Pain with intercourse	1 2 3 4	Breast lumps	1 2 3 4		
		Hot flashes	1 2 3 4			***Provider Score:*** _____	

MEN ONLY

19. Do you have now or have had any of these symptoms in the last 3 months? YES NO

Erectile difficulties	1 2 3 4	Penile discharge	1 2 3 4	Low libido	1 2 3 4	Other: ____________________
Lumps in testicles	1 2 3 4	Sores on penis	1 2 3 4	Breast lumps	1 2 3 4	
Enlarged prostate	1 2 3 4	Itchy genitals	1 2 3 4	Reduced muscle mass	1 2 3 4	***Provider Score:*** _____

GRAND TOTAL: _________

CERTIFICATE OF AUTHENTICITY

I hereby certify that the above information is true and correct within the best of my knowledge.

Signature of Patient: ______________________________________ Date: ________________

Parent or guardian signature needed if patient under 18 *mm / dd / yyyy*

HEALTH HISTORY

PAST HEALTH

1. Do **you currently**, or **have you ever** suffered from any of the following? *(if yes please circle)* **YES** **NO**

Anemia	Depression	Hepatitis	Liver disease/Cirrhosis	Skin condition
Aneurysm	Diabetes	Herpes	Lyme's disease	Sleep apnea
Arthritis	Emphysema	High/low blood pressure	Mononucleosis	Stroke
Asthma	Enlarged prostate	High cholesterol	Osteoporosis	Tendonitis
Bleeding disorder	Eye condition	HIV/AIDS	Pneumonia	Thyroid condition
Bronchitis	Gallbladder disorder	Inherited bone disorder	Pancreatitis	Torn ligaments
Bursitis	Gout	Injured/pinched nerve	Recurrent sprains	Torn muscle/tendon
Cancer	Growth disorders	Irritable bowel disease	Rheumatoid arthritis	Tuberculosis
Colitis	Heart disease/attack	Kidney stones/problems	Rheumatic fever	Venereal disease
Colon cancer	Heart murmur	Leukemia	Seizure disorder	Other: _____________

2. Have you ever been **HOSPITALIZED** or had **SURGERY?** **YES** **NO**

If yes, describe:

Year	Reason	Surgery	Outcome

3. Have you ever had any **MODERATE TRAUMA** or **ACCIDENTS?** *(e.g. Car accidents, Sports injuries, Fractures)* **YES** **NO**

If yes, describe:

Year	Trauma	Treatment	Outcome

4. Do you take any **MEDICATIONS** or **VITAMINS / HERBS?** **YES** **NO**

If yes, describe:

Med/Supp	Route (oral, etc.)	Dosage	x/day	Reason

5. Do you have any **ALLERGIES?** *(Medications, foods, environmental or other substances)* **YES** **NO**

If yes, describe:

Allergy	Allergic Response	Onset

6. Have you ever had any **SPECIAL TESTS** performed? **(X-RAY, MRI, CT, etc.)** **YES** **NO**

If yes, describe:

Test	When	Reason	Results

7. When was your **LAST PHYSICAL** by your general practitioner? **Date:** ____/____/______

Were there any problems / concerns? **YES** **NO**

If yes, describe:

WOMEN ONLY

8. Date of last menstrual period? ______________________ Are you **pregnant**? _______ Due date? _____________

Date of last pap smear? ___________________________ How many children do you have? ____________________

Date of last mammogram? _________________________ Have you ever had a "C-section?" ____________________

FAMILY HISTORY

1. Has **anyone** in your **immediate family** suffered from any of the following? *(if yes, please circle)* YES NO

Aneurysm	Colon cancer	Gout	Irritable bowel disease	Skin condition
Arthritis	Depression	Heart disease/attack	Kidney stones/problems	Stroke
Bleeding disorder	Diabetes	High/low blood pressure	Osteoporosis	Thyroid condition
Cancer	Gallbladder disorder	High cholesterol	Seizure disorder	Other: _____________

PERSONAL HISTORY

1. Describe your **WORK CONDITIONS**

	None	25%	50%	>75%
Sitting	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Light labor	☐	☐	☐	☐
Heavy labor	☐	☐	☐	☐
Prolonged postures	☐	☐	☐	☐
Repetitive stresses/motions	☐	☐	☐	☐
Overhead activities	☐	☐	☐	☐
Mental stress	☐	☐	☐	☐

2. Do you have **STRESS** in your life? YES NO

If yes, is it: ☐ Mild ☐ Moderate ☐ Severe

a) What stresses do you have? ______________________

b) How do you manage your stress? ______________________

3. Please note the following **HABITS**

	Light	Moderate	Heavy	None
Coffee	☐	☐	☐	☐
Soft drinks	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐
Recreational drugs	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐

Smoking Status: ☐ Never smoked ☐ Former Smoker ☐ Occasionally ☐ Smoke Daily If smoking, start date: ___/___/______

3. Please note the following **DIETARY HABITS**

How many ounces or glasses of water do you drink per day? ______________________

How many servings of vegetables do you eat in a day? ______________________

Do you skip meals? YES NO if yes, which meal(s) and how often? ______________________

Do you eat within 3 hours of bedtime? YES NO if yes, how often? ______________________

4. Do you **EXERCISE?** YES NO

If No, would you like to? YES NO

If Yes, answer the following:

a) What **type**? ☐ Walking ☐ Running ☐ Cycling ☐ Swimming ☐ Weightlifting ☐ Yoga ☐ Other __________

b) **How many days** per week? 1 2 3 4 5 6 7

c) How many **minutes** per session? 15-30 30-60 60-90 90-120 >120

d) What is the **Intensity** level? LOW MED HIGH

e) How many **years** have you exercised like this? __________

5. Do you **SLEEP WELL** at night? YES NO

If No, answer the following:

Do you have trouble falling asleep? YES NO

Do you wake-up frequently during the night? YES NO

Do you grind your teeth at night? YES NO

Do you feel rested in the morning? YES NO

CERTIFICATE OF AUTHENTICITY

I hereby certify that the above information is true and correct within the best of my knowledge.

Signature of Patient: ______________________________________ Date: ________________

Parent or guardian signature needed if patient under 18 *mm / dd / yyyy*

PROTECTED HEALTH INFORMATION DISCLOSURE

PLEASE REVIEW THE FOLLOWING CAREFULLY AS IT PERTAINS TO THE USAGE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

- My health information may be created or received by Falling Waters, LLC and may be in the form of written or electronic records, or spoken words. My health record may include information of my health history, health status, test results, diagnoses, treatments, procedures, prescriptions and similar types of health-related information.

- We may use health information about you to provide you with medical treatment of services. We may disclose health information about you to doctors, nurses, technicians, office staff, personnel or anyone who is involved in taking care of you and your health.

- I understand that I have the right to receive and review a written description of how Falling Waters, LLC will handle my health information. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by employees, staff and other office personnel of Falling Waters, LLC and my rights regarding my health information.

- I understand that the Notice of Privacy Practices may be revised periodically. We will not disclose your health information unless we have received written consent. I understand that a copy of summary of the most recent version of Falling Waters, LLC's Notice of Privacy Practices in effect will be posted in the waiting/reception area.

By signing this agreement I attest that I understand the information above. Our posted Privacy Health Information provides more detailed information about the usage and disclosure of your (PHI). You have the right to review and/or request a copy of this policy before you sign this consent.

Signed: ____ Date: __________________

Special Permission Request:
I give my permission for Falling Waters, LLC to leave messages regarding appointments on my home/mobile telephone answering machine.

Signed: ____ Date: __________________

I give my permission to have messages regarding treatment, billing and/or appointment status left with my spouse, partner, caregiver ________________________________ _______________ ________________________

Name of spouse/partner/caregiver Date of birth Telephone #

Signed: ____ Date: __________________

This release will revoke by written permission only. I understand that I must send a written request to Falling Waters, LLC in order to revoke this release.

Signed: ____ Date: __________________

TREATMENT CONSENT, FINANCIAL POLICY & DISCLOSURE

Name (Printed)**: ___________________________________ Date: _________________________**

Please read this agreement and sign at the end indicating that you have understood and agree to the following. Please feel free to ask any questions if you would like clarification or additional information.

- Information revealed during counseling and discussion sessions is confidential. Exceptions to this confidentiality include disclosure by you regarding intention to harm yourself or others. Your record and the information contained within it will not be disclosed to others unless you direct us to do so or unless the law authorizes or compels us to do so.
- All procedures and treatment interventions (medications, nutraceuticals, therapies, spinal manipulation, injections, minor surgical procedures, etc.) carry with them both risks and benefits. Risks include, but are not limited to injury, fracture, burns, worsening of condition, adverse reactions, stroke and/or death. Not receiving or accepting treatment recommendations also carries inherent risks, including but not limited to possible worsening of condition or disease progression, which may result in reduced quality of life and/or premature death. If unsure regarding a recommended treatment or procedure, there may be additional or alternative treatments available. Therefore, you are encouraged to ask questions if you would like additional information. No guarantees can be assured regarding the outcomes of any treatment(s) or procedure(s) recommended or performed.
- **Fees are charged for professional services, and full payment with cash, check, or credit card is due at the time these services are rendered.** Treatments, consultations (whether by phone, e-mail, or in the office), detailed correspondence on your behalf are examples of professional services.
- **You are responsible for payment for office fees, treatments, and lab tests regardless of insurance coverage.** As a courtesy, we provide insurance billing service; however, each insurance plan offers different levels of reimbursement and/or coverage for services. Many "preventive approaches" to healthcare are not covered by insurance plans. **Any expense not covered by your insurance plan is your responsibility to pay in full.** At your request, you will receive a detailed receipt to request reimbursement from your insurance carrier.
- If you have a serious health problem that requires immediate attention, you should call 911, or have someone take you to the nearest hospital emergency room. If you notice an adverse effect from one of the components of your health plan, you should discontinue it then call our office and inform the provider of your concerns.
- Treatments with other physicians or healthcare providers are not necessarily to be discontinued. Please let the doctor / provider know if you are being treated by other healthcare providers (Physicians, Counselors, Therapists, etc.). Consult your prescribing Doctor before discontinuing medications. **It is your responsibility to disclose new injuries, symptoms, conditions, treatments, medications, supplements, surgeries or diagnostic procedures performed, as well as any changes in your symptoms, conditions, medications, supplements, contact information, or treatments by other providers between visits**.
- You are welcome to bring a friend or relative to your visits if such companionship is comfortable to you.
- You are encouraged to ask questions on any health-related topic and to take an active role in your health care. Ours is a team approach, and treatment recommendations may involve encouraging you to make changes to your diet and lifestyle that can help you improve your level of health.
- Falling Waters, LLC is owned by Mark W. Davies, DC and has financial interest in its ancillary services. If you would prefer to have any ancillary services performed elsewhere we will assist you to make arrangements.

CERTIFICATE OF CONSENT

My signature below signifies my consent to treatment and assures that the contact information, health history, and other information that I have provided on my intake forms are complete and accurate. I have read, understand and agree to the information in this packet and my questions, if any, were answered to my satisfaction.

Signature of Patient: ____ Date: ___________________

Parent or guardian signature needed if patient under 18 *mm / dd / yyyy*