WELCOME to NATURALLY CHIROPRACTIC

Thank you for choosing our office for your family's chiropractic care. We are committed to providing your family with the highest quality of corrective and wellness chiropractic care available so that you and your family can enjoy an active, healthy life. We will be working together to help you and your family reach your health and wellness goals.

If you ever have any questions about your chiropractic care, please don't hesitate to ask one of our highly educated chiropractic team members. All of your questions, even the ones you haven't even thought of yet, will be answered during your Chiropractic Report.

FINANCIAL AGREEMENT

NATURALLY CHIROPRACTIC

Patient's Name ___________________________________

Policy Holder's Name (Responsible Party) ____

Birthdate ________________ SS# ___________________ Relationship to patient _________________________

Phone # (*if different from Patient*) _______________________ Employer___________________________________

Address(if different from Patient) ____

Insurance Co._______________________Policy # ________________________ Group # _____________________

FEE SCHEDULE

Service

Initial exam with computer scans
and Report of Findings.........................$110.00
Chiropractic Adjustments........................$50.00-$85.00
Periodic Dynamic Evaluation..................$50.00
Therapeutic/Rehabilitative Services........$18.00 - $38.00
Copy charges for records.........................$1.00 per page copied
Returned check ....$50.00 plus the check amount
No-show to appointment without
previous cancellation................................$50.00

We are committed to providing you with the BEST chiropractic care possible and have established our Financial Policies to achieve that goal. In accepting care, you agree to the following:

- I agree to pay for all services rendered to me at the time services are provided, unless I participate in one of the available Corrective Adjustment Plans (CAP), which are designed to be the most cost effective way to keep me and my family as healthy as possible.
- I acknowledge responsibility for my account and guarantee payment of all charges against this account.
- I understand that any portion of the balance over 90 days old will be summitted to a collection agency and subject to a finance charge.
- I agree in the event of non-payment to bear cost the cost of collections and/or court costs and reasonable legal fees, should this be required.

If I have health insurance:

- I understand and agree that health and auto insurance policies are an agreement between the insurance carrier and myself.
- I certify that I (or my dependent) have insurance coverage with the Health Insurance Company mentioned above and assign directly to Dr. Nylsa A. Correa and Naturally Chiropractic all insurance benefits.
- I authorize Dr. Nylsa A. Correa and Naturally Chiropractic to verify my benefits and acknowledge that verification is not a guarantee, since final benefits will be determined upon receipt of the claim.
- I understand that I am financially responsible for all charges whether or not paid by the insurance.
- I authorize Dr. Nylsa A. Correa and Naturally Chiropractic to release all information necessary to secure the payment of benefits.

I have read, understand and agree to abide by the above policies.

Signature of Responsible Party ____ Date ____________________

NATURALLY CHIROPRACTIC

Office Policies & Procedures

1. Symptoms: Regardless of the reason you came to our office, it is important to understand the difference between symptoms and their cause. As your spine is corrected you will have good days and bad days. Don't get caught up in this roller coaster; it is normal. You will be happiest and get the best results if you understand that this is a process designed to get you functioning at your peak level and get you on the road to wellness. This takes time and is a lifelong process. Stay focused on this outcome so you are pleased with your results and enjoy the journey.

2. Appointments: A certain number of adjustments in a given time period is necessary to get the best results from your care and create wellness in your life. While we can't predict the exact number of adjustments you will need, we do know that consistency creates the best results. Therefore it is absolutely necessary that you keep your appointments. If you need to change an appointment, please call in advance to reschedule it within 24 hours so you stay on target for wellness. *It is your responsibility to get here.* We will do all we can to accommodate you. If you miss an appointment you will be charged a visit fee. This fee is not covered by your health insurance and if you are under a care plan we will deduct a visit from your plan.

3. Hours: We set up ADJUSTMENT PRIME TIME HOURS to allow your doctor to totally focus on giving you the best care possible without distraction. The hours are the following: Monday & Thursday 9:30 am – 11:30 am, 4:00 pm – 6:00 pm and Wednesday 4:00- pm – 7:00 pm. We understand there are emergencies, but we ask that you call us to let us know if you won't be able to make it to your appointment and reschedule. If you don't show up for your appointment without previous cancellation you will be charged $50.

4. Daily Visit Procedure: Each time you arrive for your adjustment, sign in and have a seat in the reception room until you are directed to an adjusting room by the front desk chiropractic assistant with your travel card. Go back to the adjusting room and place a piece of face cover on the table, lay down on your stomach and relax until the doctor arrives. Please help keep things moving by lying down quietly and relaxing for your adjustment. When you are finished with the Doctor please take your travel card back to the front desk for check out.

5. Progress Evaluation: We want to make sure you are getting the best care possible, therefore we perform a re-evaluation to assess your progress every 10 to 12 visits. On this visit you will be taken to the Exam Room. Plan on spending approximately 30 minutes on this day. There is an additional fee for this visit unless you are on a Care Plan that is all-inclusive. Immediately following your Progress Evaluation, the doctor will share your results. At the end of your Corrective Adjustment Plan you will receive recommendations for a Wellness Adjustment Plan to help you stay as healthy as possible.

6. Results: Many factors that we have no control over may affect how quickly you respond to your care. These include your age, diet, stress level, activity level, occupation, how long you have had your vertebral subluxations, and how many subluxations are present in your spine. Regardless of these circumstances, your body has an incredible ability to heal itself. The recommendations we make will consider these factors along with the current condition of your spine. We will do all we can to get you to Wellness Care as quickly as possible.

7. Most Important: We will be asking you to make a commitment within yourself to:

- Be here when due. Stick with the program of care.
- Attend at least twice a year to our health workshops.
- Remember, the power that made the body, heals the body.

NATURALLY CHIROPRACTIC HEALTH HISTORY

Please fill out this form as completely and accurate as possible

Today's Date ______________________

Name ____ Age ________ Date of Birth _______________

Parent's name (if you are under 18) ____

Home Address ________________________________ City ________________ State ______ Zip ________

Home Phone ______________________________ Business Phone ___________________________________

Cell Phone __________________________ Email ____

Occupation __________________________ Employer ____

Business Address ____

Emergency Contact and Phone Number ____

Marital Status: S M D W Spouse/Partner Name ____

Names and Ages of Children ____

Whom may we thank for referring you to our office? ____

Reasons for seeking chiropractic care

What concerns do you feel Naturally Chiropractic can address for you?

____

____

Are these concerns affecting your quality of life? Please circle those applicable to you

Work	Y N	Driving	Y N	Sleep	Y N
School	Y N	Walking	Y N	Sitting	Y N
Exercise/sports	Y N	Eating	Y N	Love life	Y N

Health Care Practitioner History

Have you ever received Chiropractic care? Y N Name of Dr ____

How long under care? ______ days ______ weeks ______ months ______ years

Date of last visit ____________________ Why did you stop? ____________________________________

Have you consulted or do you regularly consult any of the following providers? (*check all that apply)*

Medical Physician	Naturopath	Acupuncturist	Homeopath
Massage Therapist	Psychotherapist	Energy healer	Dentist

Reason why ____

____

For Woman

Are you pregnant? Y N If pregnant, Due Date _______________ Name of OB/GYN or Midwife ____________________

Where will you be birthing your baby? Hospital / Home / Birthing Center / Other ____________________________

PHYSICAL STRESS

Have you had any accidents or injuries in your life related to any of the following? *check all that apply*

Automobile Motorcycle Bicycle Sports Playground Abuse

If yes, state type or injury and date:

____

____

Have you ever hurt/injured your spine, head, neck, ribs, chest, upper or lower back, pelvis or hips? Y N

If yes, state type or injury and date:

____

____

Have you ever hurt, broken, fractured or sprained any bones or joints? Y N
If yes, list body parts injured and dates: ____

____

Have you ever been hospitalized? Y N
If yes, state reason and dates: ____

____

Emotional Stress

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have experienced any of the emotional stresses below:

Childhood trauma	Y N	Loss of loved one	Y N	Abuse	Y N
Work or School	Y N	Divorce/Separation	Y N	Financial	Y N
Lifestyle change	Y N	Parents divorce	Y N	Illness	Y N

Chemical Stress

Chemical stress can occur when a substance that is toxic to the body is breathed, injected, taken by mouth or placed on the skin (e.g. food allergies, drug reactions, exposure to chemicals in the air, etc). The following will reveal exposures you may have had.

Were you vaccinated? Y N If yes, did you have a reaction? Y N

Have you been exposed to any of the following on a regular basis, (past or present)?

Toxic chemicalsSecond hand smoke Drug therapy Radiation Chemotherapy Other

If yes, please list____

Do you have allergies to any foods? Y N If yes, please list____

____

Do you consume any of the following presently?

Coffee/caffeine Alcohol Tobacco Over the counter drugs Prescribed drugs

Please list all medications (prescribed and over the counter)____

____

____

Quality of Life

How do you grade your physical health?	Good	Fair	Poor
How do you grade your emotional/mental health?	Good	Fair	Poor
How do you rate your overall quality of life?	Good	Fair	Poor

Do you exercise regularly? If yes, how often? ____

Do you take supplements? If yes, please list____

Do you have a special dietary regime? If yes, what? ____

---

*DOCTOR'S NOTES:*____

____

____

Recommendations: ____

____

Patient accepted: YES NO Referred

I have reviewed the information contained on this form with the patient

Dr's signature ______________________________ Date_______________

NATURALLY CHIROPRACTIC

TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective.
It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.
Chiropractic has only one goal, and that is to eliminate vertebral subluxations. On a daily basis, we experience physical, chemical and emotional stresses that often accumulate and result in these vertebral subluxations, which in turn can cause a serious loss of health and well-being. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or dissapointment.
A chiropractic adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine, by hand or mechanical means. You may feel a "click" or "pop", such as the noise when a knuckle is cracked, and you may feel movement of the joint.
Health is a state of optimal physical, mental and social well being, not merely the absence of disease.
Vertebral Subluxation is 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. Often times, the effects of these vertebral subluxations are gradual in nature and can remain undetected until the problem becomes severe. Symptoms are usually the last thing to show up in a disease process and the first thing to dissappear as the correction begins.
We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, 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 a health care provider who specializes in that area.
Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

Care Choices: Patients come to our office for a variety of reasons.

- *Crisis/relief care: symptomatic pain relief (patch up care). It corrects the most recent layer of spinal or neurological damage.*
- *Reconstructive/Corrective Care: cause of problem corrected as well as symptomatic relief (fix-up care). Concerned with corrected years of damage that occurred when there were few symptoms.*
- *Wellness/Maintenance Care: for relief and spinal correction in addition to looking forward to maintaining heightened state of wellness and vitality.*

Please choose type of care that best fits your health and lifestyle goals: (Please initial your response)

-----Relief care ------Corrective care ------Wellness care ------I would like the doctor to select the appropriate care for me

I understand that no guarantee of assurance will be made or has been made to the results that may be obtained.

I, ______________________________________have read and fully understand the above statement.

Any questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Patient's Signature ____ Date____________________

****

Consent to evaluate and adjust a minor/child

I, _________________________________, being the parent or legal guardian of _________________________ have fully read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care

Signature ____ Date_____________________

NATURALLY CHIROPRACTIC

Consent to evaluate and adjust a pregnant woman

When a pregnant woman seeks the benefits of the Webster Technique and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.
The tense muscles and ligaments in the pelvis, caused by misalignment in the sacrum, may lead to constraint in the uterus. When the uterus is torqued and constrained in this manner, it is more difficult for the baby to move into the best possible position for birth. The Webster Technique is a specific chiropractic adjustment, which corrects subluxation in the sacrum. As a result, the mother's tense pelvic muscles and ligaments relax, enhancing the physiological environment needed for normal baby positioning. We do not offer to diagnose or treat any condition. We are not turning "malpositioned" babies. We do not determine baby position. This technique is a specific chiropractic adjustment, which removes interference to the nervous system, balances pelvic muscles and ligaments, alleviates constraint to the mother's uterus allowing for optimal baby positioning. Our care is detection of and specific adjusting of vertebral subluxation.

I, ______________________________________have read and fully understand the above statement.
(please print your name)
Intial & date ________/________
****

PRIVACY PRACTICES ACKNOWLEDGEMENT

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

_You may request restrictions on your disclosures.
_You may inspect and receive copies of your records within 30 days with a request.
_You may request to view changes to your records.
_In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and it's staff.

I understand that, under the under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:
_Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
_Obtain payment from third party payers
_Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

Patient Name (Print):____

Relationship to Patient: SELF PARENT OR GUARDIAN OTHER: _____________________

Signature:____ Date:_____________________

****

I certify I received, read, understand and accept Naturally Chiropractic Office Policies and Procedures form.

Patient Signature ____

Witness ____

Health History for Pregnant Mothers

Name: ____

Prenatal History

Is this your first pregnancy? __________ How many other births have you had? _____________

How many weeks pregnant are you now? _____________

Have you experienced any traumas during this pregnancy? (Accidents or falls) _______________

Please describe ____

Any medications taken during this pregnancy? ____

Do you smoke or drink alcohol? ___________

Have you had any evaluation procedures (ultrasound, amniocentesis, chorionic villus sampling)?

____

Please list dates, frequency and reason for these procedures: _____________________________

____

How has your diet been during this pregnancy? ____

Have there been any stressful events in your life during this pregnancy? ______________________

____

What are your most significant fears associated with this birth? ______________________________

____

Who is your birth care provider? ____

Will you have someone with you at the birth for support? Please specify who:

____

Where do you plan on delivering? ____

Have you put together a birth plan? ____

Previous Birth History:

Place of birth: (circle one) Hospital / Birthing Center / Home / Other _________________________

Delivering Practitioner: (circle one)

OB/GYN Certified Nurse Midwife Certified Practicing Midwife Lay midwife

Position of Delivery: (circle one)

Lithotomy position (on back with feet up) On your side kneeling squatting Other__________________

Was labor induced? (Contractions were stimulated prior to the natural onset of labor) _______

If yes, specify type: Pitocin / Prostaglandins / Gel Applied to Cervix / Unknown

Did your care provider rupture your membranes? ________

Were contractions stimulated intravenously with pitocin once labor started? ___________

NAME OF PATIENT: ____

Did you receive any pain medications or anesthesia? _________________

Please specify type used: ____

If you had an epidural, how many centimeters were you dilated when it was administered? __________

Did you experience back pain during labor? ________ Did you deliver vaginally? _______________

Baby presentation at the time of delivery? Normal Posterior Brow Facial Breech

If breech, specify type: Footling / Frank Complete / Kneeling

Was there any visible injury to your baby? ___________

If so, where on your baby was the injury sustained? _______________________________

Did your care provider assist delivery with his/her hands? _______________

Was there any turning of the neck, or traction (pulling) applied to the neck? ____________

Were operative devices used to facilitate the birth? ______ Which type? Forceps / Vacuum / Extraction

If yes, were there any visible signs of injury to your baby? ______________

If yes, where was the injury sustained? ____

Was there a birthing coach present? Husband / Doula / Friend / other_____________________

At what week of pregnancy was your baby born? _________________________________

---

*DOCTOR'S NOTES:*____

Recommendations: ____

Patient accepted: YES NO Referred

I have reviewed the information contained on this form with the patient

Dr's signature _____________________________ Date______________