11209 N. Tatum Blvd. Ste. 140
Phoenix, AZ 85028

Dr. Sonya Bladow, DC
Dr. Christopher Bonin, DC

Your Health Profile

Please rate your overall health status:

Poor 1 2 3 4 5 6 7 8 9 10 Excellent

What are your health objectives? _____

Name/Address/Phone of the last doctor who put you on a health development program?
_____

Were you able to stay on the program? Y N How long? _____

What were your results? _____

Are you healthier today than you were 5 years ago? Y N Not Sure

Have you had previous chiropractic care? Y N
If yes, what was the doctor's name?
_____

What was the approximate date of your last visit? _____

What was the duration of your care? _____

Lifestyle

Use a Cervical Pillow: Yes No

I Prefer:
- □ Long-lasting solutions.
- □ Temporary low-cost solutions.

I Prefer:
- □ To learn every detail of my care.
- □ Just an overall explanation.

I Prefer:
- □ To let my insurance coverage control my care.
- □ Let my doctor control my care.
- □ To take control of my own care.

Doctors Initials_____

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Consent for Purposes of Treatment, Payment & Healthcare Operations

In this document, "I" and "my" refer to the patient, and the "Chiropractor" refers to Total Lifestyle Chiropractic.

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing, or providing treatment for me, obtaining payment for my healthcare bills or to conduct healthcare operations of Chiropractor. I understand that analysis, diagnosis, or treatment of me by Chiropractor may be conditional upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor. I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, my employer, or a healthcare clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, of there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right that Notice's Notice of Practices prior signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of healthcare operations of Chiropractor. The Notice of Privacy Practices for Chiropractor is available at the front desk of Total Lifestyle Chiropractic. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Printed Name of Patient _____

Signature of Patient or Personal Representative_____

Date of Signing _____

Doctors Initials_____

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TERMS OF ACCEPTANCE

When a patient seeks chiropractic healthcare 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 both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment
An 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 of the spine.

Health
A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation

A misalignment of one or more of the 24 vertebra 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.

We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend you seek the services of another healthcare provider.

We do not offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, _____ have read and fully understand the above statements. *(Print Name)*

Consent to evaluate and adjust a minor child

I,_____ being the parent of legal guardian of, _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care. All questions regarding the doctor's objectives pertaining to my/ my child's care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Patient/Guardian Signature _____ Date _____

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Authorization to Release Medical Information

I authorize the release of medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

Patient Signature_____ Date _____

Agreement for Payment of Services

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that if any amount is authorized to be paid directly to this office, it will be credited to my account. **HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY REPSONSIBLE FOR THE PAYMENT OF MY ACCOUNT.** It is the policy of this clinic to collect for services as they are rendered, unless other financial arrangements are made.

Patient Signature _____ Date _____

Doctors Initials_____

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Pertaining to HIPPA (Health Insurance Portability Act) The Patient Consent for below complies with Federal Law
Appointment Calls, Open Room Adjusting & Health Care Information

Dr. Bladow, Dr. Bonin and the staff of Total Lifestyle Chiropractic may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternative or other health related information that may be of interest to you. If this contact is made by phone and you are not home, a message will be left on your answering machine or with a family member. *By signing this form you are giving us authorization to contact you with these reminders and information.*

You can restrict the individuals or organizations to which your health care information is released or you may revoke your authorizations to us at any time, however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke the authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose, based on the authorization you give us, may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, if will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

We offer spinal adjustments in an open room style, with other patients in the same room. Occasionally comments about your symptoms, improvements or lack there of may be discussed at your office visit.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives of health related information at any time. (#164.524)

This notice is effective as of January 1, 2013. This authorization will expire seven years after the date in which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I also understand that I may receive a copy of this form when needed.

Patient Signature_____ Date_____

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X-RAY CONSENT FORM

The doctor has explained that the purpose of the x-rays about to be taken is to analyze the spine for findings associated with vertebral subluxation and to determine the appropriateness of chiropractic spinal adjustments. If the doctor discovers a non-chiropractic "unusual finding" when reviewing this x-ray, I will be informed. I then must determine if I should seek the service of an additional health care provider for advice, diagnosis, or treatment for the unusual finding. I understand that seeking advice from another type of health care provider should not interfere with the subluxation correction care provided by this office.

I fully understand the above and consent to chiropractic spinal x-rays.

Patient's signature: _____ Date: _____

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual period: _____

Patient's signature: _____ Date: _____

Consent to evaluate and take x-rays on a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above x-ray consent form and hereby grant permission for my child to receive x-rays.

Guardian's signature: _____ Date: _____

Doctors Initials_____