New Patient Registration

PATIENT INFORMATION

Name:_____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Sex: ❑ M ❑ F ❑ Other: _____ Age: _____ Date of Birth: _____ (mm/dd/yyyy)

❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced ❑ Minor

Occupation: _____ Employer: _____

Mobile #: _____ Email: _____

How did you hear about us? ❑ Internet ❑ Insurance ❑ Referral: _____ ❑ Other: _____

In case of emergency, please contact:

Name:_____ Relationship: _____

Mobile #: _____ Home #: _____ Work #: _____

In case of medical emergency, if patient is of school age, I approve treatment in my absence.

_____ _____

Parent/guardian signature Date

INSURANCE INFORMATION

Subscriber's Name: _____ Date of Birth: _____

Subscriber's SS#: _____ Relationship to Patient: _____

Insurance Company: _____

Insurance ID#: _____ Group #: _____

Is patient covered by additional insurance: ❑ Yes ❑ No

Additional Insurance Company: _____

Insurance ID#: _____ Group #: _____

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE
AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Balanced Flow Wellness, LLC, Nolan Lee, DC; Dominika M. Hertsberg, DC, Conor MacDonald, LMT, as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that *have been* or *will be* rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information

contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signature of Responsible Party

Date

Informed Consent

Informed consent for your care is a process and dialogue with your physician about the risks and benefits of proposed treatment and other available treatment options to allow you to participate and make knowledgeable decisions about your care. It is very important that you read this document in its entirety. As a patient, it is essential that you knowledgeably participate in decisions concerning the nature and course of your treatment. It is essential that you ask questions and receive sufficient information from your physician about the potential risks, proposed benefits and alternatives to your proposed treatment plan. Please DO NOT sign this document until you have had the opportunity to ask questions about your care, fully understand the care to be rendered, and have read this document in its entirety.

Chiropractic Treatment

The practice of chiropractic medicine includes many standard examination and testing procedures. These may include a physical examination, orthopedic and neurological testing, palpation, specialized instrumentations, laboratory tests, imaging examinations, physical therapy modalities, soft tissue mobilization techniques, and rehabilitative procedures among others.

A primary therapy utilized in your chiropractic treatment will be spinal manipulative therapy or adjustments. There are a number of different adjusting techniques, some utilizing specially designed equipment. Adjustments are usually performed by hand, but may be performed by hand guided instruments. A chiropractic adjustment is the application of a quick precise movement to a specified contact point of a vertebral or other joint. Joint function can be compromised in a number of ways and can affect a patient's overall health. Chiropractic manipulations or adjustments are utilized to restore or improve joint function. Adjustments may cause an audible "pop" or "click" similar to when you "crack" your knuckles. You may also feel a sense of movement at the area adjusted.

Probability and Nature of Risks Inherent in Chiropractic Adjustment and Treatment

As with any health care procedure, there are certain complications that may arise during chiropractic therapy. In chiropractic manipulative therapy, rarely, you may incur fractures, disc injuries, dislocations, and burns. Occasionally after manipulative therapy you may experience muscle strain, cervical spinal cord compression know as myelopathy, separations, or new increased or radicular tingling, numbness or pain. Some patients will feel some stiffness and soreness following the first few days of treatment. Bruising, swelling, soreness, and/or pain are not uncommon following soft tissue mobilization techniques and instrument assisted soft tissue mobilization techniques for 72 hours after treatment.

Some types of manipulation of neck have been associated with injuries to the arteries of the neck or other causes leading or contributing to rare but serious complications including stroke, paralysis or neurological dysfunction. The relationship of strokes to cervical manipulation of adjustment has been the subject of tremendous disagreement. The incidence of stroke is exceedingly rare and estimated to occur between one and one million and one in five millions cervical adjustments.

Ionizing radiation from x-ray imaging can be harmful to a fetus for those who are pregnant or might be pregnant.

Acupuncture Treatment

Acupuncture involves the insertion of pre-sterilized, disposable needles through the skin in the underlying tissues of specific points on the surface of the body. Treatment within the scope of acupuncture may include, but is not limited to acupuncture, acupressure, moxabustion (direct or indirect application of heat to acupuncture points or needles), cupping (cups made of glass or other materials placed on the skin with a vacuum created by heat or other device), electrical stimulation (use of electrical device to produce electrical stimulation on the acupuncture needles), tui-na (Chinese massage), or *gua sha* (Chinese dermal friction technique) based on traditional Chinese medical theory.

Probability and Nature of Risks Inherent in Acupuncture Treatment

As with any healthcare procedure, there are certain complications which may arise during acupuncture treatment. Rarely acupuncture may cause discomfort, pain, bruising, blistering, bleeding, localized infection at the procedure site, temporary skin discoloration, and aggravation of pre-existing conditions. Bruising, swelling, soreness, and/or pain are not uncommon following cupping and/or *gua* sha techniques for 72 hours after treatment. There are reports indicating certain acupuncture points can negatively affect pregnancy including spontaneous miscarriage. It is your responsibility to inform your practitioner if you are or suspect that you are pregnant.

Availability and Nature of Other Treatment Options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs, such as anti-inflammatory drugs, muscle relaxants, and pain killers
- Hospitalization
- Surgery

If you choose to use any of the other treatment options noted above, you should be aware that there are risks and benefits of such options that you may wish to discuss with your chiropractic physician or primary care physician.

Risks and Dangers of Remaining Untreated

Remaining untreated may result in persistent or increasing pain or other symptomology, increased loss of function, formation of tissue adhesions contributing to pain, further reduction of mobility, or worsening of your condition. Over time, if you choose to remain untreated, this may complicate future treatment and make future treatment more difficult and less effective the longer treatment is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment, acupuncture, and related treatments. I have discussed treatment options and goals, risk of various treatment options, and alternative treatment options with the doctor(s) of Balanced Flow Wellness and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Date	**Date**
Patient	**Doctor**
Signature	**Signature**
Signature of Parent or Guardian	

Chief Complaint & Health History

Name *(Last, First, MI)* _____ **DOB** *(month/day/year)* _____ **Date** *(month/day/year)* _____

CHIEF COMPLAINT

What is the main reason for your visit? _____

When did your symptoms start and/or how long have you had them? _____

Where were you when the pain/problem started? _____

Is this condition due to an accident? ❑ No ❑ Yes, ❑ Auto ❑ Work ❑ Home ❑ Other _____

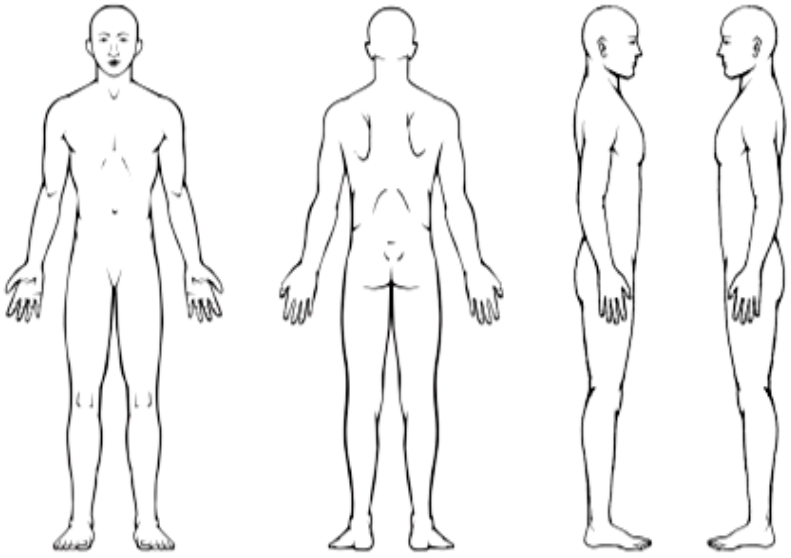
How often is the pain present? ❑ Constant ❑ Comes and goes Is your condition getting worse? ❑ Yes ❑ No

When does your pain/problem occur? _____

What makes your problem better? _____ worse? _____

What other associated problems do you have? _____

Please mark your areas of discomfort or pain on the diagram to the right.



How do you describe your discomfort or pain?

❑ Sharp ❑ Shooting ❑ Dull ❑ Aching

❑ Throbbing ❑ Numbness ❑ Burning

❑ Tingling ❑ Cramps ❑ Stiffness

❑ Other: _____

Please rate the severity of your pain/problem (circle below):

Lowest 0 1 2 3 4 5 6 7 8 9 10 Highest

Painful activities or movements: ❑ Sitting ❑ Standing ❑ Walking ❑ Lying down ❑ Other: _____

What previous treatment(s) have you received for your condition? ❑ None ❑ Medications ❑ Surgery
❑ Physical therapy ❑ Chiropractic ❑ Acupuncture ❑ Other _____

List the dates of your last:

Physical Exam		X-ray		Blood Test	
Dental Exam		CT Scan/MRI		Urine Test	

Are you or do you have reason to believe you are currently pregnant? ❑ No ❑ Yes, due date: _____

PAST MEDICAL HISTORY

Check all conditions that you have had below:

❑ AIDS/HIV	❑ Bleeding disorders	❑ Gonorrhea	❑ Mononucleosis	❑ Polio
❑ Alcoholism	❑ Breast lump	❑ Gout	❑ Multiple sclerosis	❑ Scarlet Fever
❑ Allergy shots	❑ Bronchitis	❑ Heart disease	❑ Mumps	❑ Stroke
❑ Anemia	❑ Emphysema	❑ Hepatitis	❑ Osteoporosis	❑ Suicide attempt
❑ Anorexia	❑ Epilepsy	❑ Hernia	❑ Pacemaker	❑ Thyroid problems
❑ Appendicitis	❑ Fractures	❑ Herniated disc	❑ Parkinson's Disease	❑ Tonsillitis
❑ Arthritis	❑ Glaucoma	❑ Herpes	❑ Pinched nerve	❑ Tuberculosis
❑ Asthma	❑ Goiter	❑ Miscarriage	❑ Pneumonia	❑ Tumors/growths
❑ Bulimia	❑ Chemical dependence	❑ Prosthesis	❑ Venereal disease	❑ Diabetes
❑ Cancer	❑ Rheumatic Fever	❑ Measles	❑ Whooping cough	❑ Kidney disease
❑ Cataracts	❑ High cholesterol	❑ Psychiatric care	❑ Vaginal infections	❑ Chicken Pox
❑ Ulcers	❑ Rheumatoid arthritis	❑ Liver disease	❑ Typhoid Fever	❑ Prostate problems
❑ Migraine	❑ Other: _____			

Serious injuries or illness:	**Description**	**Date**
Hospitalizations		
Broken bones		
Dislocations		
Surgeries		
Other		

Current Medications (include reason or condition)	**Allergies**	**Vitamins and Supplements**

SOCIAL HISTORY

Exercise	**Work Activity**	**Habits and Lifestyle**	
❑ None	❑ Sitting	❑ Smoking	Packs/Day _____
❑ Moderate	❑ Driving	❑ Alcohol	Drinks/Week _____
❑ Daily	❑ Standing	❑ Coffee/Caffeine	Cups/Day _____
❑ Heavy	❑ Light labor	❑ Drugs	Type/Frequency _____
	❑ Heavy labor	❑ High stress level	Reason _____

FAMILY MEDICAL HISTORY

	Age	Diseases/Conditions	If deceased, cause of death
Father			
Mother			
Siblings			
Spouse			
Children			

Please indicate which of the below you have experienced in the last 1-2 months

(1=rarely, 2=occasionally, 3=frequently, 4=constantly)

General							
Fatigue	1 2 3 4	Malaise	1 2 3 4	Diarrhea	1 2 3 4	Lightheadedness	1 2 3 4
Irritability	1 2 3 4	Constipation	1 2 3 4	Feeling Foggy	1 2 3 4	Weakness/ Tiredness	1 2 3 4
Forgetfulness	1 2 3 4						
Musculoskeletal							
Muscle Aches	1 2 3 4	Fibromyalgia	1 2 3 4	Arthritis	1 2 3 4	Joint Pain	1 2 3 4
Low Back Pain	1 2 3 4	Neck Pain	1 2 3 4	Knee Pain	1 2 3 4	Elbow Pain	1 2 3 4
Shoulder Pain	1 2 3 4	Hip Pain	1 2 3 4	Wrist/Hand Pain	1 2 3 4	Pain btw Shoulder Blades	1 2 3 4
Ankle/Foot Pain	1 2 3 4						
Neurological							
Headaches	1 2 3 4	Migraines	1 2 3 4	Dizziness	1 2 3 4	Pins/Needles in hands/feet	1 2 3 4
Tingling	1 2 3 4	Numbness	1 2 3 4				
Eyes, Ears, Nose, Throat, Respiratory							
Asthma	1 2 3 4	Stuffy Nose	1 2 3 4	Hay Fever	1 2 3 4	Sore Throat	1 2 3 4
Chronic Cough	1 2 3 4	Wheezing	1 2 3 4	Itching	1 2 3 4	Hoarseness	1 2 3 4
Drainage	1 2 3 4	Chest Congestion	1 2 3 4	Frequent Sneezing	1 2 3 4	Itchy/Watery Eyes	1 2 3 4
Shortness of Breath	1 2 3 4	Earache or Infection	1 2 3 4				

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Patient Name (print) **Signature** **Date**

Patient-Specific Functional Scale

What activities in your life are you unable to perform or are having the most difficulty with? Please rate these activities from 1 to 10 (1 = cannot perform, 10 = can perform without limitation/discomfort)

Activity	Rating
1.	
2.	
3.	
4.	
5.	
6.	

Patient Name (print) _____ **Date** _____

Patient Signature _____ **Parent or Guardian Signature** _____

Patient Privacy and Consent

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act (HIPAA). I understand that by signing this consent I authorize Balanced Flow Wellness to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day health care operations of Balanced Flow Wellness (including appointment reminder cards and confirming appointments at home or work)

I have also been informed of and given the right to review and secure a copy of the Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that Balanced Flow Wellness reserves the right to change the terms of this notice from time to time and that I may contact Balanced Flow Wellness at any time to obtain the most current copy of this notice.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Patient Name (print) _____ **Date** _____

Patient Signature _____ **Parent or Guardian Signature** _____

Communication Consent

Balanced Flow Wellness has the ability to call, text and email patients for convenient communication. Patients may be contacted through these means for appointment reminders, clinic feedback or other communication needs. Please indicate your consent for these types of communication below.

1. I consent to receiving appointment reminders and other healthcare communication from Balanced Flow Wellness via telephone. _____ (initial)
2. I consent to receive text messages from Balanced Flow Wellness for communications as stated above to my mobile phone and any number forwarded from or transferred to that number. _____ (initial)
3. I consent to email for receiving communications as stated above. _____ (initial)

1. Email Risks. Email communication has associated risks that should be considered before use.
a) Email can be immediately broadcast worldwide and be received by many intended and unintended recipients; recipients can forward email messages to other recipients without the original sender(s) permission or knowledge; users can easily misaddress an email; email is easier to falsify than handwritten or signed documents; backup copies of email may exist even after the sender or the recipient has deleted his/her copy.
b) Email containing information pertaining to diagnosis and/or treatment must be included in the protected personal health information; all individuals who have access to the protected personal health information will have access to the email messages; patients who send or receive email from their place of employment risk having their employer read their email.
2. Email Policy. Email messages sent or received which concern the diagnosis or treatment of a patient will be a part of that patient's medical record and will treat such email messages or internet communications with the same degree of confidentiality as afforded other portions of your medical record. Balanced Flow Wellness will use reasonable means to protect the security and confidentiality of email or internet communication. However, we cannot guarantee the security and confidentiality of all email or internet communication due to the above risks.
3. Email Conditions. Consent to the use of email includes agreement with the following conditions:
a) All emails to or from patients concerning diagnosis and/or treatment will be made a part of your medical record. As a part of the protected personal health information, other individuals at Balanced Flow Wellness such as physicians, nurses, other health care practitioners, insurance coordinators and insurers may have access to email messages contained in your medical record.
b) Balanced Flow Wellness may forward email messages within the practice as necessary for diagnosis and treatment. Balanced Flow Wellness will not forward email outside the practice without the consent of the patient.
c) Balanced Flow Wellness will attempt to read email promptly but cannot assure that the recipient of a particular email will read the email promptly. Email must not be used in a medical emergency.
d) Because some medical information is highly sensitive, email should not be used for communications concerning diagnosis or treatment of AIDS/HIV infection; other sexually transmissible or communicable diseases; Behavioral health, Mental health or developmental disability; or alcohol and drug abuse.
e) Balanced Flow Wellness is not liable for improper disclosure of confidential information via email or electronic communication.
f) If consent is given for the use of email, it is the responsibility of the patient to inform Balanced Flow Wellness of any types of information that he/she does not want to be sent by email.
g) It is the responsibility of the patient to protect their password or other means of access to email. Balanced Flow Wellness is not liable for breaches of confidentiality caused by the patient.
h) Not all messages sent by Balanced Flow Wellness are encrypted or utilize encryption technology. Email messages that are improperly intercepted may be readable by third-parties. Any further use of email initiated by the patient that discusses diagnosis or treatment constitutes consent to the foregoing.

I understand that my consent to communicate by phone, text and email will apply to all future communication and may be withdrawn at any time by written communication. _____ (initial)

Name	**Signature**	**Date**

HIPAA AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize Balanced Flow Wellness LLC. (BFW), its subsidiaries, and any related organizations to use and disclose information about me for the purposes of creating press releases, news stories, photographs or video clips, website and/or publications, as well as stand-alone pictures/graphics in which I may appear and/or be heard, for use in internal BFW publications and/or disclosure to external (non-BFW) media.

The information about me may include my: name, treatment modality, age, duration of treatment, treatment plan, diagnoses, city and state of residence, photographs, location of BFW treating facility and information about my life and how I came to BFW, my on-going treatment. The information may also be disclosed to external media in the form of press releases, stories, photographs or video clips. It may also be used for internal purposes or on the BFW website or through BFW's own marketing or educational campaigns. BFW will not receive any direct or indirect payment from or on behalf of any third party in exchange for the release of this information about me.

I understand the provision of health care treatment, payment for my health care and my health care benefits are not dependent on this authorization. I understand I am not required to sign this authorization, however the information will not be used or disclosed without authorization. I understand any information used or disclosed pursuant to this authorization may be subject to re-disclosure.

I understand I have the right to revoke this authorization in writing, except to the extent information has already been released pursuant to this authorization at the time of the revocation. I can revoke this authorization by sending correspondence to BFW. I hereby release, discharge and agree to hold BFW harmless from any liability that may arise from the release of information authorized above.

PATIENT CONSENT AND RELEASE AGREEMENT

I, the undersigned, grant to Balanced Flow Wellness, LLC (BFW) and its affiliated entities, licensees, successors and assigns (collectively called the "Licensed Parties") a worldwide, perpetual right and license to use, reproduce, print, publish, broadcast and rebroadcast, as well as to copyright, my testimonial statement, voice, picture, name and likeness in any and all media and types of advertising and promotion (collectively referred to as "Advertising") for the Licensed Parties and their products and services.

All right, title, and interest in and to my name, testimonial statement, voice, picture, and likeness used in Advertising pursuant to this Consent and Release, including all copyrights therein, will be the sole property of the Licensed Parties, free from any claims whatsoever by me or my employer.

I understand that I will not have any right to compensation in connection with the Licensed Parties' use of my name, testimonial statement, voice, picture, or likeness. I hereby release the Licensed Parties and their successors and assigns from any and all claims arising out of their use of my name, testimonial statement, voice, picture, and likeness as agreed to in this document, including without limitation any claims based on libel, slander, or the rights of publicity, privacy or personality. I hereby waive any right to review any Advertising and agree that no Advertisement or other material need be submitted to me for any further approval.

I acknowledge that this permission authorizes the Licensed Parties to post my testimonial statement, voice, picture, name, and likeness on third party social media web sites (including Facebook, Twitter, Instagram, and YouTube), which may require Licensed Parties to grant the owners and users of such sites a broad license to use such materials for any purpose without notice to or approval from me.

The statements attributed to me in any testimonial I provide reflect my actual experience with the Licensed Parties and my honest opinions about the Licensed Parties and/or their products and services. I understand that I have the right to revoke this Consent and Release by delivering written revocation to BFW; provided however that this will

not impose any obligation upon the Licensed Parties to recall or destroy any materials already used, published or disclosed.

This Consent and Release does not in any way conflict with any existing commitment on my part. I am of the age of 18 or older and have the right to contract in my own name and, if applicable, on behalf of my employer with respect to this Consent and Release.

I understand that the provision of health care treatment, payment for my health care, and my health care benefits are not dependent upon this Consent and Release. I understand that this Consent and Release does not obligate the Licensed Parties to make any use of any
of the rights granted herein.

Name	**Signature**	**Date**

If the patient is a minor or has a personal representative, I represent that I am the legal parent/guardian/personal representative of the Patient named above and I am not prohibited by Court Order from releasing access to the requested information.