2325 W North Avenue, Chicago, IL 60647
Phone: 312-626-0313 | Fax: 312-957-4862
Email: hello@balancedflow.today
Website: balancedflow.today

PATIENT INFORMATION

Name: ____ Date of Birth: ___________________

Preferred Name: _______________________________ Pronouns: ______________________

Age: ________________ Sex Assigned at Birth: ☐ Male ☐ Female ☐ Prefer not to Answer

Address: ____

City: _______________ State: _______ Zip: __________ Phone #: _________________________

Email: ____

How did you hear about us?

☐ Google Search ☐ Facebook ☐ Instagram ☐ TV Commercial ☐ Insurance Portal

☐ Patient Referral: ______________________________ ☐ Other: _________________________

In Case of Emergency, Please Contact:

Name: _____________________________________ Relationship to you: ____________________

Phone #: _______________________ Additional Phone #: ___________________________

In Case of Emergency, if Patient Is School Age, I approve Treatment In My Absence

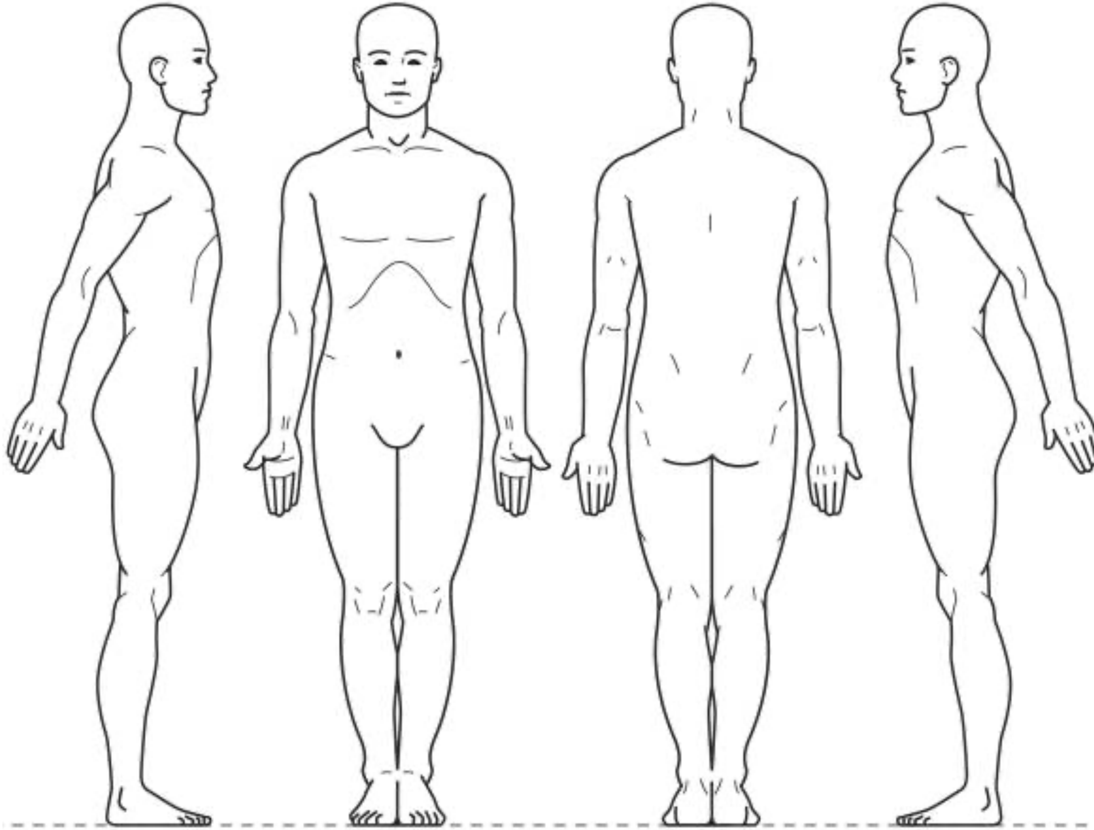
____
Printed Name of Patient or Parent/Guardian

____ ______________________
Signature of Patient or Parent Guardian Today's Date

CHIEF COMPLAINT

What is the main reason for your visit? ____

Please mark your areas of discomfort or Pain on the diagram below:



How do you describe your discomfort or pain? ☐ Sharp ☐ Cold ☐ Shooting ☐ Dull

☐ Aching ☐ Throbbing ☐ Numbness ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness

☐ Other: ____

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

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

Painful Activities: ☐ Sitting ☐ Walking ☐ Lying Down ☐ Standing

Other: ____

Are you or do you have any reason to believe you are pregnant? ☐ Yes ☐ No

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PAST MEDICAL HISTORY

Check all conditions that have had down below:

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

Describe any previous serious Injuries or illnesses: **Date**

Hospitalizations: ____ ___________

Surgeries: ____ ___________

Other: ____ ___________

Current Medications/Vitamins & Supplements:

____

____

Allergies: ____

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SOCIAL HISTORY

How often do you exercise? ____

What type of work do you do? ____

____

Select any that apply below:

☐ Smoking, Packs per day: ____

☐ Alcohol, Drinks per week: ____

☐ Coffee/Caffeine, cups per day: ____

☐ Drugs, Type and Frequency: ____

☐ High Stress Levels, Reason: ____

FAMILY MEDICAL HISTORY

☐ Heart Disease ☐ Epilepsy ☐ Hypertension ☐ Glaucoma ☐ Stroke ☐ Bleeding Disorders

☐ Cancer ☐ Kidney Disease ☐ Diabetes ☐ Other: ___________________________________

List your family members that have had any of the conditions selected above:

____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can adversely affect 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 or Parent/Guardian Name Patient or Parent/Guardian Signature Date

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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.

Trigger Point Injections

Trigger Points are painful areas of muscle that are tender and may feel like tight bands or knots when pressed. Pressing on the trigger point will "trigger" pain at the area of pressure and often in other areas. Trigger points are overactive muscle areas that can come from stress, using the muscle too much, or problems with spine or posture. Your provider may want to treat the problem with a trigger point injection. During treatment, the trigger point is found by palpation and sometimes marked. The area is cleaned and can be sprayed with a cooling spray for numbing before inserting a very thin needle through the skin into the trigger point area to "break it up". This may cause a small "twitch" that can be felt. This is often a sign that the trigger point has been reached. The needle may be moved gently in and out of the trigger point area, changing direction to make sure it is all treated. The area will be massaged afterwards. Then a Band-Aid will be placed over the area if needed. Most trigger point treatments take 15 seconds, or less, each area.

Probability and Nature of Risks Inherent in Trigger Point Injections

As with any health care procedure, there are certain complications that may arise from trigger point injections including temporary soreness, minor bleeding, bruising, dizziness and rare instances of allergic reaction, infection, scarring, collapsed lung or cardiovascular or cerebral problems. The risk of infection is very small, as is the risk of bleeding after the injection. Patients taking blood thinning medication (such as Coumadin) can be more prone to bleeding. Please inform your provider if you are taking these medications. Most patients do not experience any side effects at all. However, a small percentage may feel a pinpoint area of muscle soreness that should fade away within 1-2 days. Please notify your medical provider if you are allergic to Marcaine (Bupivacaine), Lidocaine, or any medications that end in "Caine". Some providers use other medicines during trigger point treatment. The selection of medication to be used for your trigger point treatment will be performed by your provider, and you will be informed of all medications used.

Chiropractic Treatment

The practice of chiropractic medicine includes many standard examinations, treatment, and testing procedures. These may include a physical examination, orthopedic and neurological testing, palpation, physical therapy modalities, therapeutic exercises, specialized instrumentations, laboratory tests, imaging examinations, 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 many 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 various 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" like 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 known 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 million cervical adjustments.

Electrical cell signaling treatment (EcST)

Electrical cell signaling treatment (EcST) is a form of electrical stimulation that is an FDA approved, non-invasive treatment that uses specific electrical energy frequency waves, along with harmonic frequencies to enhance cellular chaos. This stimulates and activates the cellular “healing process”. EcST uses electronic signal energy waves produced by high frequencies. These therapeutic pulsed energy waves are comfortable and delivered directly into the desired anatomical region. In the process, the signals will imitate, facilitate, and exhaust the nerves.

Currently, this treatment has been undergoing clinical research, and is published in medical journals to prove the ability to regenerate nerves. This device is used for the following FDA clinical indications:

- For adjunctive treatment of post-traumatic pain syndromes.
- For management and symptomatic relief of chronic (long-term) intractable pain
- As an adjunctive treatment in the management of post-surgical pain problems.
- Relaxation of muscle spasms.
- Prevention or retardation of disuse atrophy
- Increasing local blood circulation
- Muscle reeducation
- Immediate post-surgical stimulation of calf muscle to prevent phlebothrombosis (blood clots)
- Maintaining or increasing range of motion

Primarily, this device is used for the management and symptomatic relief of chronic (long-term) intractable pain, such as, peripheral neuropathy related to diabetes, chemotherapy, alcohol, vitamin deficiencies, sciatica, low back pain, entrapment syndromes, or neuropathy from unknown causes.

Vitamin Injections: The vitamin injections are a subcutaneous injection of a mixture of vitamins and minerals that help facilitate repair of the soft tissues and nerves. With this type of injection, a short needle is used to inject into the tissue layer between the skin and the muscle. Vitamins given this way are absorbed more slowly over a period of 24 hours. We rotate the injection sites depending on the locations of your symptoms to help prevent buildup of scar tissue from continuous injections in the same area. A cold spray may be used to reduce tenderness and pain at the injection site but may cause skin discoloration. Some side effects that can occur with subcutaneous injections at the site are soreness, redness, bruising, itching, and burning.

Probability and Nature of Risks Inherent in Electrical cell signaling treatment (EcST):

As with any healthcare procedure, there are specific situations in which EcST should not be used or extreme caution needs to be exercised because it may be harmful to the person. These situations include, and are not limited to:

- Thrombophlebitis - an inflammatory process that causes a blood clot to form and block one or more veins
- Pacemaker
- Irregular heartbeat or abnormal heartbeat**

- Active local skin infection, caused by bacterial or viral infections
- Open wounds or active bleeding at the placement site
- Intermittent muscle spasms
- Epilepsy**
- Heart conditions**
- Recent surgical procedures where muscle contractions may disrupt the healing process

****May still receive treatment based upon symptoms and electrode placement. Please discuss with the provider**

FDA Clinical Indications: management/symptomatic relief of chronic "long term pain". Adjunctive treatment of post traumatic pain syndromes. Relaxation of muscle spasms. Neuromuscular reeducation. Prevention or retardation of disuse atrophy. Increase local blood circulation. Maintain or increase range of motion. Immediate post-surgical stimulation of the affected area to prevent phlebothrombosis.

Availability and Nature of Other Treatment Options

Other treatment options for your condition may include Self-administered over-the-counter analgesics, rest and prescription drugs, such as anti-inflammatory drugs, muscle relaxants, pain killers, Surgery, and or Hospitalization. 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 healthcare provider

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 BELOW UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

I have read or have had read to me the above explanation of the treatments that may be provided to me. I have discussed treatment options and goals, risk of various treatment options, and alternative treatment options with the doctor(s) of Balanced Flow Medical 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 acknowledge that no guarantees have been made concerning the outcome of the procedure. 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.

______________________________	______________________________	__________
Patient or Parent/Guardian Name	Patient or Parent/Guardian Signature	Date
______________________________	______________________________	__________
Healthcare Provider Name	Healthcare Provider Signature	Date

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PATIENT PRIVACY

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 or Parent/Guardian Name	Patient or Parent/Guardian Signature	Date

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.

- I consent to receiving appointment reminders and other healthcare communication from Balanced Flow Wellness via telephone.
- 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.
- I consent to email for receiving communications as stated above.

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.

My signature below indicates that I have read and consent to all the information listed above. I also 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.

______________________________	______________________________	____________________
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HIPPA 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 or Parent/Guardian Name	Patient or Parent/Guardian Signature	Date

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 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.

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

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Balanced Flow Medical, LLC, as well as all contractors, 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 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(ices). 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 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.

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