



## CURRENT CONCERNS:

REASON(S) FOR SEEKING TREATMENT FOR YOUR CHILD: \_\_\_\_\_

HISTORY OF INJURY TO THE AREA?  Y  N

IF YES, PLEASE EXPLAIN: \_\_\_\_\_

DATE OF INJURY/ONSET OF SYMPTOMS: \_\_\_\_/\_\_\_\_/\_\_\_\_

CURRENT PAIN LEVEL: (NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORST PAIN IMAGINABLE)

DESCRIPTION OF PAIN:  ACHING  SHARP  BURNING  NUMBNESS  TINGLING

SELF-CARE:  ICE  HEAT  OTHER \_\_\_\_\_

OTHER HEALTHCARE PROVIDERS SEEN FOR THIS CONCERN:  Y  N

IF YES, NAME OF PRACTITIONER \_\_\_\_\_ APPROXIMATE DATE OF TREATMENT \_\_\_\_/\_\_\_\_/\_\_\_\_

HAS YOUR CHILD EVER BEEN TREATED BY A CHIROPRACTOR?  Y  N

IF YES, APPROXIMATE DATE OF LAST TREATMENT \_\_\_\_/\_\_\_\_/\_\_\_\_

## GENERAL HEALTH HISTORY:

CURRENT HEIGHT: \_\_\_\_\_ CURRENT WEIGHT: \_\_\_\_\_

PLEASE CHECK ALL THAT APPLY TO YOUR CHILD'S HEALTH HISTORY...

CONGENITAL HEART DEFECT

CANCER

DIABETES

KIDNEY PROBLEMS

SCOLIOSIS

ASTHMA

NECK PAIN

BACK PAIN

HEADACHES

CONSTIPATION

DIARRHEA

DIGESTIVE PROBLEMS

EAR ACHES/INFECTIONS

COLIC/FUSSINESS

SLEEPING PROBLEMS

BED WETTING

ACID REFLUX

SKIN IRRITATION

OTHER CONDITIONS \_\_\_\_\_

ALLERGIES/SENSITIVITIES \_\_\_\_\_

MEDICATIONS \_\_\_\_\_

VITAMINS/SUPPLEMENTS \_\_\_\_\_

ACCIDENTS/INJURIES \_\_\_\_\_

PEDIATRICIAN/FAMILY PHYSICIAN \_\_\_\_\_



**PATIENT NAME:** \_\_\_\_\_

**ASSIGNMENT OF BENEFITS AND RELEASES:**

- I AUTHORIZE AND DIRECT THAT PAYMENT BE MADE DIRECTLY TO A L WAGNER FAMILY CHIROPRACTIC PC, DR. ASHLEY L. WAGNER, FOR ANY AND ALL INSURANCE BENEFITS OR REIMBURSEMENT FOR SERVICES RENDERED, WHICH AMOUNTS WOULD OTHERWISE BE PAYABLE TO ME UNDER ANY INSURANCE OR PRE-PAID HEALTHCARE PLAN.
- I AUTHORIZE THE RELEASE OF ANY INFORMATION CONCERNING MY HEALTH AND HEALTHCARE SERVICES TO ANY INSURANCE COMPANY, ADJUSTER, PRE-PAID HEALTH PLAN, DOCTOR OR ATTORNEY INVOLVED IN THIS CASE.
- I UNDERSTAND THAT THERE IS NO GUARANTEE THAT MY INSURANCE COMPANIES OR PRE-PAID HEALTHCARE PLAN WILL COVER OR PAY FOR ALL OF MY CHARGES. NOTWITHSTANDING DENIAL, REDUCTION OF BENEFITS OR FAILURE TO PAY FOR ANY REASON, I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL REMAINING CHARGES.

I AUTHORIZE DR. ASHLEY L. WAGNER TO DISCUSS MY CASE WITH ANY OTHER HEALTHCARE PROFESSIONAL AT HIS/HER DISCRETION.

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**DATE**

**PATIENT SIGNATURE**

**WITNESS:**

I REVIEWED THIS AUTHORIZATION FORM VERBALLY WITH THE PATIENT AND HE/SHE APPEARS TO UNDERSTAND IT FULLY.

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**DATE**

**WITNESS SIGNATURE**



**CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION**

PATIENT NAME: \_\_\_\_\_

**PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY**

**PURPOSE OF CONSENT:** BY SIGNING THIS FORM, YOU WILL CONSENT TO OUR USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT ACTIVITIES, AND HEALTHCARE OPERATIONS.

**NOTICE OF PRIVACY PRACTICES:** YOU HAVE THE RIGHT TO READ OUR NOTICE OF PRIVACY PRACTICES BEFORE YOU DECIDE WHETHER TO SIGN THIS CONSENT. OUR NOTICE PROVIDES A DESCRIPTION OF OUR TREATMENT, PAYMENT ACTIVITIES, AND HEALTHCARE OPERATIONS, OF THE USES AND DISCLOSURES WE MAY MAKE OF YOUR PROTECTED HEALTH INFORMATION, AND OF OTHER IMPORTANT MATTERS ABOUT YOUR PROTECTED HEALTH INFORMATION. A COPY OF OUR NOTICE ACCOMPANIES THIS CONSENT. WE ENCOURAGE YOU TO READ IT CAREFULLY AND COMPLETELY BEFORE SIGNING THIS CONSENT.

WE RESERVE THE RIGHT TO CHANGE OUR PRIVACY PRACTICES AS DESCRIBED IN OUR NOTICE OF PRIVACY PRACTICES. IF WE CHANGE OUR PRIVACY PRACTICES, WE WILL ISSUE A REVISED NOTICE OF PRIVACY PRACTICES, WHICH WILL CONTAIN THE CHANGES. THOSE CHANGES MAY APPLY TO ANY OF YOUR PROTECTED HEALTH INFORMATION THAT WE MAINTAIN. YOU MAY OBTAIN A COPY OF OUR NOTICE OF PRIVACY PRACTICES, INCLUDING ANY REVISIONS OF OUR NOTICE, AT ANY TIME BY CONTACTING: ASHLEY L. WAGNER TELEPHONE: 701-557-7455

**RIGHT TO REVOKE:** YOU WILL HAVE THE RIGHT TO REVOKE THIS CONSENT AT ANY TIME BY GIVING US WRITTEN NOTICE OF YOUR REVOCATION SUBMITTED TO THE CONTACT PERSON LISTED ABOVE. PLEASE UNDERSTAND THAT REVOCATION OF THIS CONSENT WILL NOT AFFECT ANY ACTION WE TOOK IN RELIANCE ON THIS CONSENT BEFORE WE RECEIVED YOUR REVOCATION, AND THAT WE MAY DECLINE TO TREAT YOU OR TO CONTINUE TREATING YOU IF YOU REVOKE THIS CONSENT.

**SIGNATURE**

I, \_\_\_\_\_ (PRINT), HAVE HAD FULL OPPORTUNITY TO READ AND CONSIDER THE CONTENTS OF THIS CONSENT FORM AND YOUR NOTICE OF PRIVACY PRACTICES. I UNDERSTAND THAT, BY SIGNING THIS CONSENT FORM, I AM GIVING MY CONSENT TO YOUR USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT ACTIVITIES AND HEALTH CARE OPERATIONS.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

RELATIONSHIP TO PATIENT (IF APPLICABLE): \_\_\_\_\_

AUTHORIZED PROVIDER REPRESENTATIVE SIGNATURE: \_\_\_\_\_



## **INFORMED CONSENT TO CHIROPRACTIC TREATMENT**

THERE ARE RISKS AND POSSIBLE RISKS ASSOCIATED WITH CHIROPRACTIC MANIPULATIVE TREATMENT USED BY DOCTORS OF CHIROPRACTIC. IN PARTICULAR YOU SHOULD NOTE:

1. WHILE RARE, SOME PATIENTS MAY EXPERIENCE SHORT TERM AGGRAVATION OF SYMPTOMS, OR MUSCLE AND LIGAMENT STRAINS OR SPRAINS AS A RESULT OF CHIROPRACTIC MANIPULATIVE TREATMENT TECHNIQUES. ALTHOUGH UNCOMMON, RIB FRACTURES HAVE ALSO BEEN KNOWN TO OCCUR FOLLOWING CERTAIN CHIROPRACTIC PROCEDURES;
2. THERE ARE REPORTED CASES OF STROKE ASSOCIATED WITH VISITS TO MEDICAL DOCTORS AND CHIROPRACTORS. RESEARCH AND SCIENTIFIC EVIDENCE DOES NOT ESTABLISH A CAUSE AND EFFECT RELATIONSHIP BETWEEN CHIROPRACTIC TREATMENT AND THE OCCURRENCE OF STROKE. STUDIES SUGGEST THAT PATIENTS MAY BE CONSULTING MEDICAL DOCTORS AND CHIROPRACTORS WHEN THEY ARE IN THE EARLY STAGES OF A STROKE. IN ESSENCE, THERE IS A STROKE ALREADY IN PROGRESS. HOWEVER, YOU ARE BEING INFORMED OF THIS REPORTED ASSOCIATION BECAUSE A STROKE MAY CAUSE SERIOUS NEUROLOGICAL IMPAIRMENT, OR EVEN DEATH. THE POSSIBILITY OF SUCH INJURIES OCCURRING IN ASSOCIATION WITH A CERVICAL ADJUSTMENT IS EXTREMELY REMOTE;
3. THERE ARE RARE REPORTED CASES OF DISC INJURIES IDENTIFIED FOLLOWING CERVICAL AND LUMBAR SPINAL ADJUSTMENT, ALTHOUGH NO SCIENTIFIC EVIDENCE HAS DEMONSTRATED SUCH INJURIES ARE CAUSED, OR MAY BE CAUSED BY SPINAL ADJUSTMENTS OR OTHER CHIROPRACTIC TREATMENT;
4. THERE ARE INFREQUENT REPORTED CASES OF BURN OR SKIN IRRITATION IN ASSOCIATION WITH THE USE OF SOME TYPES OF ELECTRICAL THERAPY OFFERED BY SOME DOCTORS OF CHIROPRACTIC.

I ACKNOWLEDGE I HAVE READ THIS CONSENT AND I HAVE DISCUSSED, OR HAVE BEEN OFFERED THE OPPORTUNITY TO DISCUSS WITH MY CHIROPRACTOR THE NATURE AND PURPOSE OF CHIROPRACTIC TREATMENT IN GENERAL, AND THE CONTENTS OF THIS CONSENT.

I CONSENT TO THE CHIROPRACTIC TREATMENT RECOMMENDED TO ME BY MY CHIROPRACTOR, INCLUDING ANY RECOMMENDED SPINAL ADJUSTMENTS. I INTEND THIS CONSENT TO APPLY TO MY PRESENT AND FUTURE CHIROPRACTIC CARE.

PATIENT/LEGAL GUARDIAN NAME (PRINT): \_\_\_\_\_

PATIENT/LEGAL GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PROVIDER ACKNOWLEDGEMENT OF CONSENT: \_\_\_\_\_