TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care 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.

Vertebral Subluxation Complex (VSC): 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.

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

Adjustment: 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 using our hands or instruments depending on your individual needs.

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 examination, we encounter non-chiropractic or unusual findings, we will advise you. It 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 VSC.

PRIVACY POLICY

The patient understands and agrees to allow this office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive you medical records, please inform our office.

I have read and fully understand the above statements.

All 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.

_____ _____

Signature Date

Informed Consent to Chiropractic Treatment

The State of Iowa requires that every patient be informed of the risks of treatment and the alternatives prior to the beginning of treatment. The following is Kenkel Family Chiropractic's informed consent. We intend this consent form to cover the entire course of treatment for your present condition and for any future conditions for which you seek treatment at this or any other Kenkel Family Chiropractic clinic.

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to manipulate your joints. You may hear a "click" or a "pop", similar to when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or traction, as well as exercise instruction may also be used.

Possible risks and probability: There are inherent risks in any and all treatment delivered by any health care provider, ranging from taking a single aspirin to complicated brain surgery. Chiropractic is no exception. Although we take every precaution, there are indeed some slight risks to chiropractic manipulation. The risk is very minor to almost nonexistent in any treatment of extremities. The risks involved in treatment to the spine excluding the neck are several. A list from the least to most serious would include muscular strain (rare), ligamentous sprain (rare), fractures (rare), and injury to the intervertebral disks, nerves or spinal cord (very rare). The risk involved in the treatment of the neck would include any on the preceding list but also include the remote possibility of cerebrovascular injury, or stroke (very, very rare: chances are one in one million to one in ten million). A minority of patients may notice stiffness or soreness after the first few days of treatment (common). The ancillary physical therapy procedures could produce skin irritation, burns, or other minor complications (rare).

Other treatment options that could be considered may include the following:

Over-the-counter analgesics. The risks of these medications include irritation to the stomach, liver, and kidneys, and other side effects in a significant number of cases.

Medical care, typically anti-inflamatory drugs, tranquilizers, and analgesics. Risks of these drugs include numerous undesirable effects, usually more serious than those listed above and patient dependence in a significant number of cases.

Surgery in conjunction with medical care adds the risks of adverse reaction to anesthesia (which includes death), as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition, and make future rehabilitation more difficult.

Concerns or questions: Please ask your Doctor of Chiropractic. We at Kenkel Family Chiropractic have gone to great lengths to make your health and safety our top priority. We will be glad to explain any concern about treatment you might have. Suffice to say we will only recommend treatment for you that we would feel comfortable having performed on ourselves.

I have read the above explanation of chiropractic treatment. I also had the opportunity to ask questions and have them answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

_____ _____ _____

Printed name of Patient **(Parent Signature if Patient is a Minor)** **Date**

NEW PATIENT INFORMATION
(Age: 12-17 years)

Date:_____

PATIENT INFORMATION

Patient's Name:_____ Any Nickname:_____
Reason for visit:_____
Sex: __Male __Female Date of Birth:_____ Age:____ Social Sec. #:_____
Home Phone #:_____
Home Address:_____
Who may we thank for referring you?_____

FAMILY INFORMATION

Mother's Name:_____ Father's Name:_____
Home Phone #:_____ Home Phone #:_____
Work Phone #:_____Work Phone #:_____
Parent's Marital Status: __Married __Single __Divorced __Widowed
List Ages of other Children in Family:_____

PAYMENT INFORMATION

Please read and sign our Financial Agreement
If you have insurance that may cover chiropractic services, please provide your current insurance card so that we may make a copy. Additionally, please enter the following information to assist in processing your insurance.

Insured's Name_____ DOB_____SS#_____
Insurance Company Name_____ Phone No._____
Insurance Company Address to send claims_____
Employer_____ Group No._____ Insured's ID#_____

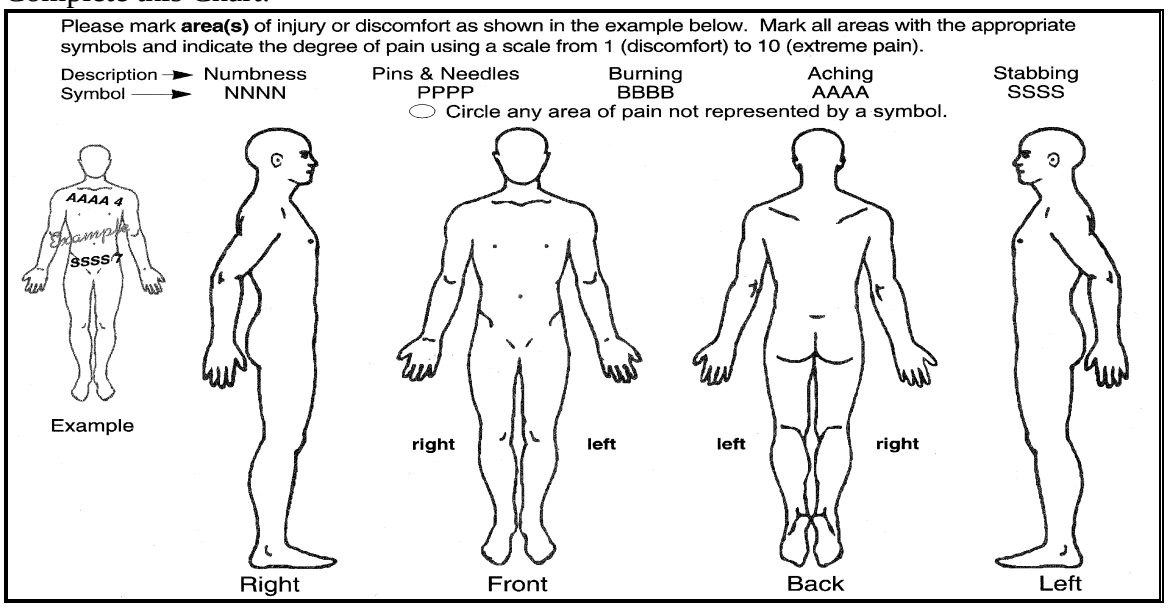
CONSTENT TO TREAT

Being the parent or legal guardian of this child, I hereby authorize this office and its doctors to examine and administer care to my son/daughter named_____ as the examining/ treating doctor deems necessary.
I understand and agree that I am personally responsible for payment of all fees charged by this office for such care.
Parent's Name:_____ Signature:_____
Date:_____ Witnessed by:_____

Patient Information

Reason for your visit: _____
When did your symptoms appear: _____
Is this condition progressively getting worse: ( ) Yes ( ) No ( ) same
How often do you have this pain/symptoms: _____
Does it interfere with your: ( ) Work ( ) Sleep ( ) Daily Routine ( ) Recreation
Movements that are painful to perform: ( ) Sitting ( ) Standing ( ) Lying ( ) Walking

Complete this Chart:



What treatment have you already received for your condition: ( ) Medication ( ) Surgery
( ) Physical Therapy ( ) Chiropractic ( ) None
( ) Other:_____

Name and address of other doctor(s) who have treated you for your condition:
_____

Date of last: Physical Exam_____Spinal X-ray_____
Spinal Exam_____ Dental Visit_____
Blood Test_____Urine Test_____

Exercise	**Work Activity**	**Habits**	
( )None	( )Sitting	( )Smoking	Packs/Day _____
( )Moderate	( )Standing	( )Alcohol	Drinks/week_____
( )Daily	( )Light Labor	( )Coffee/Caffeine	Cups/day_____
( )Heavy	( )Heavy Labor	( )High Stress Level	Cause_____

Are you pregnant? ( )Yes ( )No Due Date:_____

Patient Information

Injuries/ Surgeries in past **Description** **Date**

Falls_____

Accidents_____

Sport Injuries_____

Head Injuries_____

Broken Bones_____

Dislocations_____

Surgeries_____

Medications	**Allergies**	**Vitamin/Herb/Minerals**

Do you have any other concerns about your health?

_____

_____

Signature_____ **Date_____**

Doctor's Signature_____ **Date_____**