INFORMED CONSENT FOR CHIROPRACTIC CARE

By beginning chiropractic care at Compass Chiropractic LLC, I acknowledge that the objective of the chiropractor is to identify and correct vertebral subluxations through the administration of a chiropractic adjustment. The adjustment is a specific manual force applied to the spine by hand or instrument, in which a quick thrust or impulse is delivered to the involved area(s). In some cases, Kevin McDade DC may need to touch otherwise sensitive areas of the body to properly deliver an adjustment or analyze my spine. I acknowledge that some techniques require the body to be placed into seemingly awkward positions to better receive the chiropractic adjustment. I hereby request and consent to the performance of chiropractic care and various other procedures and modalities, on myself (or on the patient named below for whom I am legally responsible) by the licensed doctor of chiropractic, Kevin McDade DC.

Many patients report benefits while under chiropractic care including increased range of motion, pain relief, and others. Although most people do respond positively to care, no guarantees of cure have been implied or given. As with any health care procedure, there some associated risks which your doctor is required to bring to your attention. Though uncommon, you should note the possibility of: fracture, disc injury, muscle strain, ligament sprain, dislocation, and costovertebral separation. Strokes have been reported following chiropractic manipulation. The probability of this is exceedingly rare, estimated between one in one million and one in two million, and can be further reduced by screening procedures. Complications generally result from an underlying weakness of the bone or tissue which will be screened for during the initial exam. I understand all such risks and complications.

I understand that I am ultimately responsible for my health, and therefore may seek concurrent care from other related health care fields on my own accord. I agree to allow this office to use my confidential health information for the purposes of treatment, payment, healthcare operations and coordination of care with my medical physician(s) about my condition and treatment.

As of today, all of my questions have been adequately answered, but I am free to discuss any concerns with the doctor as the need arises. In the event that my conduct or cooperation become contrary to this agreement, Kevin McDade DC has the right to remove me from his care.

I have voluntarily read, understand, and agree to the aforementioned principles. By my signature below, I consent to all treatments deemed by this office to be in my best interest. I intend this document to cover the entire course of care, now and in the future, and agree to its provisions. I hereby authorize Kevin McDade DC, or whomever he designates as an assistant, to administer treatment to:

Printed Name: _____

Patient Signature: _____ Date: _____

Consent to Treatment of a Minor Child:

I hereby authorize Kevin McDade DC, and/or whomever he may designate as assistants, to administer treatment as deemed necessary to _____.

Signature of Parent/Legal Guardian: _____ Date: _____

Relationship to Minor: _____

HIPAA - Health Insurance Portability and Accountability Act
Notice of Privacy Policy

Compass Chiropractic LLC
13146 Midlothian Turnpike
Midlothian, VA 23113
804-499-6020

The following is an explanation of our Privacy Policy and your rights as a patient.

- Our office does not distribute or make available to any outside source your "protected health information," or (PHI).
- Your personal health information is secure and used only for treatment, claims submission to third party insurance carriers for the purposes of payment, and other health care operations.
- A family member may be present when taking a case history, hearing the results of exams or tests, or during normal office visits. Family or friends will only have access to your PHI with your written authorization.
- Our office may send you seasonal, birthday, or reminder cards to the address supplied on your intake forms.
- Our office may call you to confirm or reschedule an appointment. We may leave a message on the answering machine unless you have specifically instructed us to the contrary.
- You have the right to withdraw consent and terminate care at any time for any reason. A withdrawal of consent must be made in writing.
- You have the right to ask questions about the status of your health at any time.
- You have the right to view and copy your own file. Copying and mailing charges may apply.

By my signature below, I acknowledge that I have read, understand, and agree with the privacy policies set forth by Compass Chiropractic LLC. At my request, I am entitled to view and keep a copy of this abbreviated form or the corresponding full privacy statement, which is also made available on the practice's website: www.CompassChiroVA.com.

Printed Name:_____

Patient Signature: _____Date:_____

Compass Chiropractic LLC
13146 Midlothian Turnpike
Midlothian, VA 23113
Phone: 804.499.6020
Fax: 804.499.6030

Diagnostic X-Ray Consent Form

Patient Consent to X-Ray:

I authorize the performance of diagnostic X-ray on myself, which Compass Chiropractic LLC considers necessary or advisable in the course of my examination and treatment. At this time, I know of no condition which the taking of X-rays would further complicate.

Printed Name: _____

Patient Signature: _____ Date:_____

Consent to X-Ray a Minor:

I am a parent or legal guardian of (patient) _____, who is a minor, _____years of age. I hereby authorize the performance of diagnostic X-rays on this minor by Compass Chiropractic LLC for further diagnostic purposes. At this time, I know of no condition which the taking of X-rays would further complicate.

Patient Name: _____

Parent/Guardian Signature: _____ Date:_____

Females Regarding Possibility of Pregnancy:

X-rays, particularly those involving the pelvis, can be hazardous to an unborn child. It is advisable that, in women of child-bearing potential, X-rays be taken in the first ten (10) days following the onset of a menstrual cycle, as this is generally considered to be safe for X-ray exams.

With these considerations in mind, I certify that to the best of my knowledge I am NOT pregnant, and the doctor has permission to perform diagnostic X-rays.

Patient Signature: _____ Date:_____

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AUTHORIZATION OF INSURANCE BENEFITS:

I, _____, authorize and direct that payment be made directly to:
(Printed Name)

COMPASS CHIROPRACTIC LLC
13146 MIDLOTHIAN TURNPIKE
MIDLOTHIAN, VA 23113

for any and all insurance benefits or reimbursement of services rendered by Compass Chiropractic LLC which amounts would otherwise be payable to me under my insurance or pre-paid health plan.

I further understand that if my insurance carrier mistakenly sends payment to me for services incurred in this office, I agree to surrender those payments upon receipt. However, if I pay the full cost of my visit, then no assignment will be reported by this provider and any reimbursements or payments available from my insurance company will be sent directly to me.

_____ _____
Patient Signature Date

PAYMENT AGREEMENT:

I understand that there is no guarantee that my insurance company or pre-paid health plan will cover or pay for charges I incur. In the event of denied claims, reduction of benefits, or failure of my insurance company to pay for any reason, I understand that I am fully responsible for all remaining charges. This is so even if the results of my care are not as expected.

_____ _____
Patient Signature Date

Compass Chiropractic LLC

Pediatric Health Profile

A Parent/Guardian must fill this out if the child is under 12 years old.

Welcome to Compass Chiropractic! We look forward to working with you and your family. A patient's health is not based on symptoms or lack of symptoms. For instance, a tooth is not considered healthy when it has decay, even if there is no pain. A chiropractor checks for painless spinal misalignments that damage the nerves. Our focus is on removing this nervous system interference, allowing your child's body to express health naturally.

Demographic Information:

Full Name: _____ Date of Birth: _____

Mailing Address: _____

Age: _____ Years _____ Months _____ Weeks Height/Length: _____

Grade: _____ Weight (lbs): _____

Parent/Guardian Information:

Full Name: _____ Phone: _____

Mailing Address (if different): _____

Relationship to Patient: _____ Email: _____

How did you hear about us/Who referred you? _____

At our office we are interested in your entire family's health and well-being. Please mention below any health conditions or concerns you may have about yourself or other members of your family:

Self: _____ Spouse: _____

Other Children: _____ Other: _____

Prenatal History: this section applies only to children 6 and under

Any complications during pregnancy? ❑ No ❑ Yes, _____

Birth Type: ❑ Home ❑ Birthing Center ❑ Hospital Labor length: _____hours

Gestational age at birth: ❑ Under 37 weeks ❑ 37-42 Weeks ❑ Over 42 weeks

Any complications during the delivery? ❑ No ❑ Yes, _____

Any congenital anomalies/birth defects? ❑ No ❑ Yes, _____

Delivery Method (check all that apply): ❑ Vaginal ❑ Forceps ❑ Vacuum Extraction ❑ Cesarean-section

Feeding History:

Breast-fed? ❑ No ❑ Yes How long? _____

Formula-fed? ❑ No ❑ Yes Age when he/she was first introduced? _____ Months _____ Weeks

Does or did your baby consistently prefer feeding more on one side than the other? ❑ No ❑ Yes, _____

Introduced to solid foods at: _____ Months ❑ Not yet been introduced to solid foods

Introduced to cow's milk at: _____ Months ❑ Not yet been introduced to cow's milk

Medical History:

Doctor/Pediatrician Name: _____ Last Visit: _____

Office/Clinic Name: _____ Town: _____

Hospitalizations/Surgeries: check all that apply and explain below

❑ Spine ❑ Brain ❑ Heart ❑ Lung ❑ Hip (R/L) ❑ Shoulder (R/L)

Age: _____ Area: _____ Procedure: _____

Age: _____ Area: _____ Procedure: _____

Accidents/Injuries: includes car accidents, serious falls, sports injuries, broken bones, etc.

Age: _____ Area injured: _____ How? _____

Age: _____ Area injured: _____ How? _____

Allergies? ❑ No ❑ Yes, _____

Medication(s): please list all over-the-counter or prescription medications taken in the last year

Medication	Reason	Current or Past

Family History: this refers only to siblings, parents, and grandparents

❑ Seizures ❑ Diabetes ❑ Kidney Disease ❑ Other: _____

Social History:

Does your child play any contact sports (wrestling, football, gymnastics, etc.)? ❑ No ❑ Yes, _____

Does your child avoid or fear social environments with other children? ❑ No ❑ Yes, _____

Vaccination History: ❑ Declined vaccinations ❑ Up to date on all vaccinations ❑ Still deciding

Please describe any adverse reactions to vaccinations: _____

Has your child been to a chiropractor before? ❑ No ❑ Yes, Last Visit: _____

Systems Review: has your child ever had a problem with any of the following? Check all that apply.

General
❑ Cancer
❑ Recurring fevers
❑ Eczema/Rashes
❑ Excess TV/Video games
❑ Personality changes

Neurological
❑ Seizures
❑ Headaches
❑ Numbness/Tingling
❑ Bed wetting
❑ Delayed potty-training

Gastrointestinal
❑ Reflux
❑ Colic
❑ Jaundice
❑ Constipation
❑ Food Sensitivity (Gluten, Dairy)

Developmental
❑ Autism
❑ Asperger's
❑ Difficulty concentrating
❑ ADD/ADHD
❑ Other: _____

Musculoskeletal
❑ Neck stiffness
❑ Hip disorders
❑ Difficulty walking
❑ "Growing" pains
❑ Broken bones

EENT
❑ Ear infections
❑ Frequent colds/flu
❑ Persistent cough
❑ Asthma
❑ Allergies

Female Only
❑ First period before age 12
❑ Irregular bleeding pattern
❑ Menstrual cramping
❑ Inconsistent cycle lengths
❑ Pain during cycle
❑ Use of birth control

Primary Complaint:

What is the main reason for your child's visit? ❑ Wellness check ❑ Specific Problem(s), fill in below.

_____

_____

Do you think your child's current diet, environment, or physical activity level contributed to their problem(s)?
❑ No ❑ Yes, please explain: _____

_____

When did this first start? _____ ❑ Started suddenly ❑ Started gradually

The problem is on the: ❑ Right ❑ Left ❑ Both sides ❑ N/A

The problem is: ❑ Constant ❑ Frequent ❑ On and off ❑ Occasional

How severe is this problem on a scale of 1-10, with 10 being the worst: _____ /10

What have you found makes this problem better or worse? _____

This problem is interfering with (check all that apply):

❑ School ❑ Sleep ❑ Concentration ❑ Daily Routine ❑ Playing/Recreation ❑ Family cohesion

Signatures:

Did we miss something? Please indicate if there is anything else you would like us to know about your child.

_____

_____

_____

I have read and completed the information and certify it to be true to the best of my knowledge. I hereby permit this office to use my responses to provide my child with chiropractic care, according to the state's regulations.

Patient Name (printed): _____

Signature of Parent/Guardian: _____ Date: _____