Initials _____

Brennon Kelly, D.C.
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PREGNANCY INTAKE PAPERWORK

Maintain health and prepare for delivery

Welcome to RISE Chiropractic!

- Initial the top right corner of each page.
- Complete all questions. (For any question that does not apply to you, respond "N/A" for Not Applicable.)

1. **Today's Date:** _____
2. **Have you ever received chiropractic care?** ☐ No ☐ Yes, **(Were x-rays taken?)** ☐ No ☐ Yes, **(Year):** _____
   (Include doctor's name): _____
3. **Has anyone in your family ever received chiropractic care?** ☐ No ☐ Yes
   (Include family member & doctor's name): _____
4. **Who may we thank for referring you to our office?** _____

PERSONAL INFORMATION

5. **Full Name:** _____ **Preferred Name:** _____
6. **Date of Birth:** _____ **Age:** _____
7. **Street Address:** _____
8. **City:** _____ **State:** _____ **Zip:** _____
9. **Home Phone:** _____ **Work Phone:** _____
10. **Cell Phone:** _____ **Cell Phone Provider:** _____
11. **Email:** _____
12. **Occupation:** _____ **Employer:** _____
13. **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: _____
14. **Full Name of Spouse:** _____
15. **Spouse's Occupation:** _____ **Spouse's Employer:** _____
16. **Name of Emergency Contact:** _____ **Phone:** _____
    (His or Her relationship to you): _____
17. **Who is responsible for your finances?** ☐ Myself ☐ Both Myself & My Spouse ☐ My Spouse
    ☐ My Parent(s) / Guardian(s) ☐ Other: _____ **Phone:** _____
18. **Name(s) & age(s) of your children:** _____
    _____
    _____

HEALTH GOALS

20. Select the specific areas of your life that you want to improve:

☐ Relieve Pain / Discomfort
☐ Relieve Muscle Tension
☐ Improve Mobility / Flexibility
☐ Improve Posture
☐ Restore Proper Function
☐ Strengthen Immune System
☐ Restore Emotional Health
☐ Increase Self Confidence
☐ Improve Focus / Concentration
☐ Improve Mood / Temperament
☐ Increase Energy
☐ Stay Active / Exercise
☐ Get Adequate Sleep
☐ Drink More Water
☐ Improve Diet / Nutrition
☐ Maintain Healthy Body Weight
☐ Create A Birth Plan
☐ Maintain Sense Of Humor
☐ Find Support Group / Mom Group
☐ Have A Natural Labor / Delivery
☐ Reduce Medication(s)
☐ Financial Stability
☐ Treat Injury: _____
☐ Treat Illness: _____
☐ Quit Unhealthy Habit: _____
☐ Other: _____

Initials _____

CASE HISTORY

21. Do you have any genetic disorders or disabilities? ☐ No ☐ Yes, **(Explain):** _____

_____

22. Have you ever had a serious illness or health emergency? ☐ No ☐ Yes, **(Explain, include the year):**

_____

_____

23. Have you ever had an operation? ☐ No ☐ Yes, **(List operation(s), include the year):**

_____

_____

24. Have you ever been in an auto accident? ☐ No ☐ Yes, **(Include the year):** _____

25. Have you ever been unconscious as a result of an injury, illness, or bodily dysfunction?
☐ No ☐ Yes, **(Explain):** _____

26. Have you ever fractured a bone? ☐ No ☐ Yes, **(Explain):** _____

_____

27. Do you have any allergies? ☐ No ☐ Yes, **(Explain):** _____

PRE-PREGNANCY & CONCEPTION

28. Did you receive chiropractic care <u>BEFORE</u> your pregnancy?
☐ No ☐ Yes, **(Approximate length of Care):** _____Years _____Months _____Weeks _____Days

29. List any drug / medication, contraceptive, vitamin / supplement or natural remedy that you took prior to your pregnancy and record how long before your pregnancy you took it:

_____

_____

_____

30. Did you experience any fertility issue(s) or miscarriage(s) prior to your pregnancy?
☐ No ☐ Yes, **(Explain):** _____

_____

PREGNANCY & LIFESTYLE

31. When was the first day of your last menstrual period (LMP)? _____

32. What is your expected / calculated due date? _____

33. What trimester & week of pregnancy are you currently? Trimester: _____ **Week:** _____
(*If you are currently at or beyond 36 weeks of pregnancy, explain the position of your baby:)

_____

34. List the name of your ☐ Doctor / ☐ Midwife: _____

35. Is this your first pregnancy? ☐ Yes ☐ No, **(It's my** _____ **pregnancy.)**
(Explain your previous pregnancy, labor & delivery, and birthing experience(s). Include the total amount of weeks pregnant, the duration of labor & delivery & any complication(s) / intervention(s) that occurred):

_____

_____

_____

_____

36. Do you have a birth plan? ☐ No ☐ Yes, **(Explain. *If you plan to follow the same plan as your previous pregnancy include any changes):** _____

_____

_____

_____

37. Do you plan on having or have you had any ultrasounds taken during your pregnancy?
☐ No ☐ Yes, **(Include, number of times during each trimester): 1st T:**_____ **2nd T:**_____ **3rd T:**_____

38. Are you taking any educational classes regarding pregnancy, labor & delivery, birth, or parenting?
☐ No ☐ Yes, **(Explain):** _____

39. Do you plan on having a doula, birth coach, or other support team present during your labor / delivery?
☐ No ☐ Yes, **(Explain):** _____

40. Would you like to have your chiropractor available during labor & delivery and / or soon after birth?
☐ No ☐ Yes, **(Explain):** _____

41. Would you like to establish an account for your baby here at our office?
☐ No ☐ Yes, **(Our team will help you!)** ☐ Undecided, **(Explain):**_____

Initials _____

PREGNANCY & LIFESTYLE CONTINUED...

42. Select how you plan to feed your new born baby, (Check all that apply): ☐ Breastfeed: Breastmilk ☐ Pump / Bottle Feed: Breastmilk ☐ Bottle Feed: Formula
(Additional Comments):_____

43. Do you plan to vaccinate your child? ☐ No ☐ Yes, **(Explain):** ☐ On Schedule ☐ On A Delayed Schedule ☐ Undecided ☐ Other, **(Explain):** _____

44. Have you experienced any nausea or morning sickness during your pregnancy?
☐ No ☐ Yes, **(Check all trimesters that apply):** ☐ 1st Trimester ☐ 2nd Trimester ☐ 3rd Trimester
(Additional Comments):_____

45. Have you experienced any trouble sleeping during your pregnancy? ☐ No ☐ Yes, **(Explain):** _____
_____

46. Have you experienced any complications, serious illness, slip / fall, injury, or health emergency during your pregnancy? ☐ No ☐ Yes, **(Explain):** _____
_____

47. Do you smoke? ☐ No, I Never Have ☐ No, But I Have In The Past ☐ Yes, **(Explain):**
_____

48. Are you regularly exposed to secondhand smoke? ☐ No ☐ Yes, **(Explain):** _____

49. Have you had any alcohol during your pregnancy? ☐ No ☐ Yes, **(Explain):** _____
_____

50. Have you taken any antibiotic drug(s) during your pregnancy?
☐ No ☐ Yes, **(Approximate date last taken):** _____

51. Have you received any vaccines during your pregnancy?
☐ No ☐ Yes, **(Approximate date last taken):** _____

52. Are you taking any over-the-counter / prescription drug, vitamin / supplement or natural remedy?
☐ No ☐ Yes, **(List the name & reason for taking):** _____
_____

53. Do you experience any social, behavioral, or emotional issues? ☐ No ☐ Yes, **(Explain):** _____
_____

54. Have you served in the US Military? ☐ No ☐ Yes
(Check all branches of service that apply): ☐ Army ☐ Marine Corps ☐ Navy ☐ Air Force ☐ Coast Guard
(Check your current status): ☐ Active Duty ☐ Reserve ☐ National Guard ☐ Retired ☐ Veteran ☐ Student
(Additional Comments):_____

55. What does your typical daily activity involve? (Check all that apply): ☐ Low Stress ☐ High Stress
☐ Light Lifting: _____lbs. ☐ Heavy Lifting: _____lbs. ☐ Working At A Computer: _____Hours
☐ Excessive Sitting: _____Hours ☐ Excessive Standing: _____Hours ☐ Excessive Driving: _____Hours
☐ Other, **(Explain):** _____

56. In regards to your current work / employment, select all that apply to you:
☐ Employed ☐ Self Employed ☐ Unemployed ☐ Stay-At-Home-Mom ☐ On Maternity Leave
☐ Working _____ Hours / Week At Place Of Business ☐ Working _____ Hours / Week At Home
☐ I plan to work until I'm _____ weeks pregnant. ☐ I plan to work through pregnancy until labor / delivery

57. Select all electronic devices that you use on a daily basis, (Include your typical length of use):
☐ Smart Phone: _____ hour(s) ☐ Tablet: _____ hour(s) ☐ Television: _____ hour(s)
☐ Desktop Computer: _____ hour(s) ☐ Laptop Computer: _____ hour(s)

58. Do you have any digestive issues? ☐ No ☐ Yes, **(Check all that apply):** ☐ Heartburn / GERD ☐ Acid Reflux
☐ Bad Breath ☐ Nausea ☐ Vomiting ☐ Stomach Pain / Cramps ☐ Bloating ☐ Gas ☐ Gallstones ☐ Ulcers
☐ Constipation ☐ Diarrhea ☐ Painful Bowel Movements ☐ Foul-Smelling Stool ☐ Blood In Stool
☐ A Sensitivity To: _____ ☐ A Digestive Disease / Disorder:_____

59. How many days per week do you typically eat the following types of food?
Fruits:____ Vegetables:____ Meat / Poultry:____ Seafood:____ Eggs:____ Dairy:____ Beans / Legumes:____
Bread / Grains:____ Soy:____ Nuts / Seeds:____ Fats / Oils:____ Artificial Sweeteners / Added Sugars:____
Processed Foods:____ Fried Foods:____ Juices / Sugared Beverages:____ Caffeinated Beverages:____
(Additional Comments):_____

60. Record your current weight & height. Weight: _____lbs. **Height:** _____ft. _____in.

61. How often do you exercise? ☐ Never ☐ In The Past ☐ Occasionally ☐ _____times per week ☐ Daily

62. List your regular physical activities: _____

63. List your hobbies & interests: _____

CURRENT SYMPTOMS

64. Review the symptoms / conditions listed below and select all those that you currently experience:

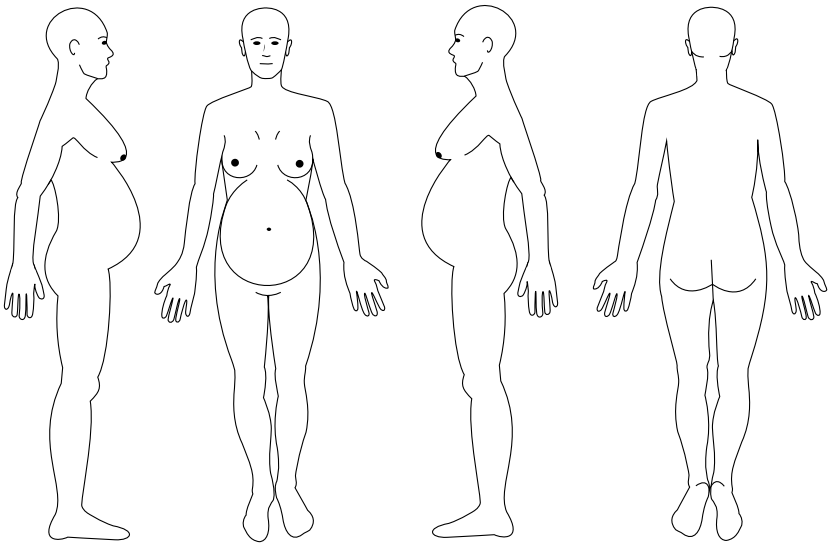
- ☐ Acid Reflux
- ☐ ADHD / ADD
- ☐ Allergies
- ☐ Ankle / Foot Pain
- ☐ Anxiety
- ☐ Arm Pain
- ☐ Arthritis / Joint Pain
- ☐ Asthma
- ☐ Athletic Injury
- ☐ Autism Spectrum
- ☐ Auto Accident
- ☐ Cancer
- ☐ Carpal Tunnel
- ☐ Chest Pain
- ☐ Chronic Cold / Flu
- ☐ Chronic Fatigue
- ☐ Chronic Pain
- ☐ Depression
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Digestive Problems
- ☐ Disc Problems
- ☐ Dizziness
- ☐ Ear Pain
- ☐ Elbow Pain
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Gallbladder Problems
- ☐ Headaches / Migraines
- ☐ Hearing Problems
- ☐ Heart Problems
- ☐ Hemorrhoids
- ☐ High Blood Pressure
- ☐ Hip Pain
- ☐ Irritable Bowel
- ☐ Kidney Problems
- ☐ Knee Pain
- ☐ Leg Pain / Cramp
- ☐ Liver Problems
- ☐ Low Back Pain
- ☐ Low Blood Pressure
- ☐ Lung / Respiratory Problems
- ☐ Mid Back Pain
- ☐ Muscle Spasm
- ☐ Nausea
- ☐ Neck Pain
- ☐ Nosebleeds
- ☐ Numbness / Tingling
- ☐ Pancreas Problems
- ☐ Pelvic Pain
- ☐ Poor Posture
- ☐ Restless Sleep
- ☐ Round Ligament Pain
- ☐ Sciatica
- ☐ Scoliosis
- ☐ Shallow Breathing
- ☐ Shoulder Pain
- ☐ Sinus Problems
- ☐ Skin Problems
- ☐ Sports Injury
- ☐ Stiffness
- ☐ Stomach Problems
- ☐ Stress
- ☐ Swelling Legs / Feet
- ☐ Thyroid Problems
- ☐ Tight Muscles
- ☐ TMJ (Jaw Pain)
- ☐ Ulcers
- ☐ Upper Back Pain
- ☐ Urinary Problems
- ☐ Vaginal Bleeding
- ☐ Vertigo
- ☐ Vision Problems
- ☐ Wrist / Hand Pain
- ☐ Other: _____ _____

☐ I **DO NOT** have any of the symptoms / conditions listed above. **(If selected, skip ahead to page 5.)**

65. In the diagram below, use the symbols provided to mark the figures in relation to where you are experiencing symptoms on your body.

SYMBOLS

A = Dull Ache
B = Burning
D = Deep Boring Pain
E = Sensitive / Tender
F = Stiff / Tight
N = Numb
P = Pressure
R = Radiating
S = Sharp / Stabbing
T = Tingling
U = Pounding
X = Excruciating Pain
O = Other: _____



66. When did your symptom(s) begin? _____Years Ago _____Months Ago _____Weeks Ago _____Days Ago
(Additional Comments): _____

67. Did your symptom(s) begin as a result of an injury? ☐ No ☐ Yes, **(Explain):** _____
_____

68. Since first noticing the symptom(s), is it: ☐ Getting Better ☐ Staying The Same ☐ Getting Worse

69. When do you experience your symptom(s): ☐ Morning ☐ Afternoon ☐ Night ☐ Constant All Day
☐ Comes & Goes During The Day ☐ Increases During The Day ☐ Decreases During The Day ☐ During Sleep
☐ Only During Specific Activities, **(Explain):** _____
☐ Other, **(Explain):** _____

70. Does your symptom(s) move or travel from one area of your body to another? ☐ No ☐ Yes, **(Explain):**
_____

71. What have you already tried that HAS NOT helped to relieve your symptom(s)? _____
_____

72. What have you already tried that HAS helped to relieve your symptom(s)? _____
_____

Initials _____

INITIAL ASSESSMENT

73. NAME: _____ **DATE:** _____

74. Select all emotional, physical, and chemical stress that you have experienced in the past 3 months.

☐ Lack of Sleep	☐ Increase In Exercise	☐ Anxiety	☐ Social / Relational Stress
☐ Poor Diet / Nutrition	☐ Decrease In Exercise	☐ Depression	☐ Death of A Loved One
☐ Poor Water Intake	☐ Lack Of Energy	☐ Overwhelmed	☐ Hospitalization
☐ Slip / Fall	☐ Excessive Sitting	☐ Financial Stress	☐ Surgery / Operation
☐ Sports Injury	☐ Excessive Standing	☐ Occupational Stress	☐ Increase In Medication
☐ Pregnancy / Labor	☐ 12+ Hour Work Days	☐ Academic Stress	☐ Decrease In Medication

☐ Other: _____

75. Use the following 0 -10 scale of discomfort to answer the remaining questions on this page.

NONE	MILD			MODERATE			LIMITING			SEVERE
0	1	2	3	4	5	6	7	8	9	10
										
I am free from any symptom. I can do all my daily activities. My quality of life is great.	I barely notice the symptom, but when I do, it causes me some discomfort. I can do most of my daily activities. My quality of life is good.			I notice the symptom and it causes me discomfort. I can only ignore the symptom for a short period of time. I can do some of my daily activities. My quality of life is okay.			I am in constant distress from the symptom. It disrupts my ability to think, work, and maintain social relationships. I can not do many of my daily activities. My quality of life is poor.			I am in excruciating pain from the symptom and it causes me agony. I am ill, delirious, and / or bedridden. I can not do any of my daily activities. My quality of life is miserable.

76. Select which statement is true for you.

☐ I **DO** experience symptoms. ☐ I **DO NOT** experience symptoms. **(If selected, skip ahead to page 6.)**

77. Write your main symptom here:

Place an "X" in the box to rate your answer to each question below.	0	1	2	3	4	5	6	7	8	9	10
Rate your discomfort from the symptom RIGHT NOW.											
Rate your discomfort from the symptom ON AVERAGE.											
Rate how close to "0" your discomfort gets AT ITS BEST.											
Rate how close to "10" your discomfort gets AT ITS WORST.											

78. If you have another symptom write it here:

Place an "X" in the box to rate your answer to each question below.	0	1	2	3	4	5	6	7	8	9	10
Rate your discomfort from the symptom RIGHT NOW.											
Rate your discomfort from the symptom ON AVERAGE.											
Rate how close to "0" your discomfort gets AT ITS BEST.											
Rate how close to "10" your discomfort gets AT ITS WORST.											

79. If you have another symptom write it here:

Place an "X" in the box to rate your answer to each question below.	0	1	2	3	4	5	6	7	8	9	10
Rate your discomfort from the symptom RIGHT NOW.											
Rate your discomfort from the symptom ON AVERAGE.											
Rate how close to "0" your discomfort gets AT ITS BEST.											
Rate how close to "10" your discomfort gets AT ITS WORST.											

*** If you have more symptoms, simply ask a team member at the office for another form.**

Initials _____

ACTIVITIES OF DAILY LIVING

80. Use the 0 -10 scale to rate your level of discomfort when doing the activities listed below.

- Place an "X" in the box to mark your rating. (Mark the "N/A" box for any activity Not Applicable to you.)

NONE	MILD			MODERATE			LIMITING			SEVERE
0	1	2	3	4	5	6	7	8	9	10
										

PERSONAL HYGIENE & DAILY CARE

ACTIVITY	RATING											ADDITIONAL NOTES:
	0	1	2	3	4	5	6	7	8	9	10	N/A	
Bathing / Showering													
Grooming Hair													
Brushing Teeth													
Using The Toilet													
Dressing The Upper Body													
Dressing The Lower Body													

DAILY PHYSICAL ACTIVITIES

ACTIVITY	RATING											ADDITIONAL NOTES:
	0	1	2	3	4	5	6	7	8	9	10	N/A	
Standing													
Walking													
Sitting													
Squatting													
Kneeling													
Reaching Overhead													
Bending Forward													
Turning Left													
Turning Right													
Move From Lying To Sitting													
Move From Sitting To Standing													
Move From Standing To Sitting													

FUNCTIONAL ACTIVITIES

ACTIVITY	RATING											ADDITIONAL NOTES:
	0	1	2	3	4	5	6	7	8	9	10	N/A	
Sleeping													
Eating													
Going Up & Down Stairs													
Getting In & Out Of Car													
Driving													
Using A Computer													
Focusing / Concentrating													
Preparing Food													
Household Chores													
Lifting Children													
Carrying Bag / Purse													

SOCIAL, RECREATIONAL, & OTHER ACTIVITIES

ACTIVITY												ADDITIONAL NOTES:
	0	1	2	3	4	5	6	7	8	9	10	N/A	
Running / Hiking													
Sexual Activity													
Hobbies / Other													

FAMILY HEALTH HISTORY

81. Place an "X" in the box below to show if you or your family members have ever had the following conditions.

- **If there is more than one family member per category, use an "X" to represent each individual.**
- **If you are helping someone fill out this form, use "SELF" to represent his or her conditions.**

82. Are you adopted? ☐ No ☐ Yes, **(Complete the "SELF" column below and any other column if applicable.)**

CONDITION	SELF	SPOUSE	SON(S)	DAUGHTER(S)	FATHER	MOTHER	SIBLING(S)
Acid Reflux / Heartburn / GERD							
ADD / ADHD							
Allergies							
Anxiety							
Arthritis / Joint Pain							
Asthma / Difficulty Breathing							
Bed Wetting							
Birth Defect							
Cancer							
Colic							
Convulsions / Epilepsy							
Depression							
Diabetes							
Digestive Problems							
Disc Problems							
Ear Problems / Hearing Loss							
Family Member Is Deceased							
Fibromyalgia / Muscle Pain							
Frequent Cold / Flu							
Gall Bladder Problems							
Headache / Migraines							
Heart Problems							
High / Low Blood Pressure							
HIV / AIDS							
Impotence / Sexual Dysfunction							
Kidney Problems							
Learning Disability							
Liver Problems							
Menstrual Dysfunction							
Mood Changes / Irritable							
Neck Pain / Back Pain							
Prostate Problems							
Sciatica							
Scoliosis							
Sinus / Drainage Problems							
Skin Problems							
Sleep Problems							
Thyroid Problems							
Tremors							
Vertigo / Dizziness							
Vision Problems							
Other:							

Initials _____

TERMS OF ACCEPTANCE

Here at RISE Chiropractic the term **Practice Member** is used instead of "patient" as "patient" suggests illness or injury, and many whom we serve are healthy and seeking wellness rather than symptom management. A Practice Member is an active participant in his or her chiropractic care, and is therefore invited to ask any questions or express any concerns that he or she may have. Practice Members can expect quality service and leadership from RISE Chiropractic as they regain control of their health. With the utilization of state of the art advanced technology, a complete analysis of your spine will be administered first to detect the presence of vertebral subluxation and to monitor your progress. Please read and sign this form stating that you understand the items explained below. If there is anything that is unclear please ask questions before you sign. If you refuse to sign this form, the doctor reserves the right to refuse care.

INFORMED CONSENT FOR CHIROPRACTIC CARE

I hereby consent to give the doctor of chiropractic, and anyone working in the RISE Chiropractic office authorized by the chiropractor, permission and authority to care for me. Chiropractic tests, diagnosis, analysis, and adjustments are very safe and beneficial and rarely cause any risks. In rare cases, underlying physical defects, deformities or pathologies may make the Practice Member prone to injury. It is the responsibility of the practice member to make it known, or to learn through health care procedures if he or she is suffering from latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the chiropractor. The doctor of chiropractic will not give any treatment or care if he or she is aware that such care should not be used for a particular condition or circumstance. Your doctor of chiropractic is a licensed primary care provider, and is available to work with all other types of providers. I understand that if I am accepted as a Practice Member at RISE Chiropractic, I am authorizing them to proceed with any treatment that they deem necessary. I understand that following the doctor's recommended care plan is essential to maximizing my healing and reaching optimal health through chiropractic. Furthermore, any questions that I have regarding chiropractic care, will be explained to me upon my request.

AUTHORIZATION FOR X-RAYS

By signing this page below, I confirm that **I AM** currently pregnant. Therefore I **DO NOT** authorize RISE Chiropracticto perform diagnostic x-rays of me at this time.

I understand that specific postural x-rays may be necessary for the identification of the location, type, and severity of vertebral subluxation, as well as for the diagnosis and identification of latent or dangerous conditions requiring medical attention.

Therefore **I DO** authorize RISE Chiropractic to perform diagnostic x-rays of me **AFTER** my pregnancy.

X-rays may also be used to show progress after a period of recommended chiropractic care.

At your request, you can receive a copy of your x-rays to a disc for the mandated fee of $15.00.

AUTHORIZATION FOR RELEASE OF INFORMATION & ASSIGNMENT OF BENEFIT

By signing below, I recognize that I am financially responsible for all services rendered to me regardless of insurance or benefit. I understand that RISE Chiropractic, is a cash-office and that I will have to pay for the full cost for services up front and that I am responsible for submitting any insurance claim to my insurance to request reimbursement. I recognize that any health insurance policy is an arrangement between me and my insurance carrier. I hereby authorize RISE Chiropractic to release all necessary information concerning my health condition to any billing company, insurance company, attorney, and/or adjuster in order to process any claim for reimbursement of charges incurred by me. In addition I authorize RISE Chiropractic to release any information regarding my health condition to other health care providers involved in my care. This assignment will remain in effect until revoked by me in writing. I agree that a photocopy of this form is to be considered as valid as the original. I confirm that all information I have provided is true and correct to the best of my knowledge. I confirm that I have read and fully understand this agreement and authorize RISE Chiropractic to proceed with chiropractic care.

83. SIGNATURE: _____ **DATE:** _____

Initials _____

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to your health information and records.

RISE Chiropractic, understands the importance of privacy and we are committed to maintaining the confidentiality of your protected health information **(PHI)** in compliance with the Health Insurance Portability and Accountability Act of 1996 **(HIPAA)**. We have developed office policies and procedures that protect your personal and health information when used within our office and any devices used to copy or transfer this data. We assure you that your information will only be shared as required and only for the purpose of administering your case and obtaining payment for services. Be assured that without your permission, your health information will not be used for any other purpose.

The following ways are how your PHI may be used within our office to provide you the best care and services possible:

- To provide treatment, obtain payment, and conduct health care operations.
- To schedule appointments and send reminders.
- To communicate with your family, friends, emergency contact, and / or caregivers with your authorization.
- As permitted or required by the law.
- For certain activities when the law requires it.

The following describes your rights regarding your PHI. You may:

- Request to inspect any copy of your records.
- Request to amend incomplete or inaccurate information in your records.
- Receive an accounting of certain disclosures of your health information.
- Ask for additional privacy protections (although your request may be declined).
- Ask for confidential communications in a particular manner.
- Receive a paper copy of this Notice.
- File a complaint without penalty.

RISE Chiropractic reserves the right to change this privacy policy as allowed by law and to make the new notice apply to health information already received as well as any information received in the future. A copy of our current notice is available upon request. The notice will display the effective date.

If you believe that we have not properly respected the privacy of your PHI, you may file a complaint with our office by calling (337) 324-3031, sending a letter to our office address 805 B Albertson Pkwy. Broussard, LA 70518 or by emailing risechirola@gmail.com

By signing below, I confirm that I have received and reviewed this notice and understand how health information about me may be used and disclosed and how I can get access to my health information and records.

84. SIGNATURE: _____ **DATE:** _____

85. Remember to initial the top right corner of each page.

TESTIMONIAL CONSENT

RISE Chiropractic celebrates and displays chiropractic testimonials in our office and on our social media outlets to educate others about the benefits of chiropractic care.

86. Do you authorize RISE Chiropractic to display your chiropractic testimonial?

☐ Yes, I **DO**.
☐ No, I **DO NOT**.

BELOW IS FOR OFFICE USE

VISIT NOTES		DR. INITIALS