Welcome to the beginning of optimal health!

Revolution Health Center - A Wellness Way Affiliate would like to thank you for choosing us to partner with you as you embark on your journey towards optimal health! We've developed this guide to help **you** prepare for your new patient appointment.

In order for us to begin designing your personalized treatment plan, we need to know a little more about you. **There are several online forms that must be completed and submitted a minimum of three (3) business days prior to your new patient appointment.**

- **Go to** www.murfreesborotn.thewellnessway.com
- Follow the instructions to complete all of the steps.

Please read the following frequently asked questions. Initial after each question**.**

What do I need to bring to my new patient appointment? _____ **(initial)**

1. The completed and signed consent forms from Step 1 above
2. This form - completed and signed
3. Your lab records from the past two (2) years

How long will my first appointment last? _____ **(initial)**

- Anywhere from 30 minutes to two (2) hours depending on the patient.
  This allows for a thorough review of your history; a physical examination; and any lab testing deemed necessary. We also allow ample time for you to ask questions.

Will I be changing rooms to see other doctors in the office? _____ **(initial)**

- Maybe
  Some new patient evaluations involve several doctors and/or nurses.

Are my appointment charges billable to insurance? _____ **(initial)**

- We are a cash only clinic and do not bill to any insurance companies.

What about Functional Medicine? How is that billed?

- Functional medicine or nutrition services are not billable to insurance at this time. _____ **(initial)**

Will there be a potential for lab work and if so, how are labs billed? _____ **(initial)**

- Lab work results are very important and will typically assist the doctor in determining the plan of care. If prior lab work has not been completed, our doctors may recommend lab testing at your first appointment. This typically involves blood work or test kits.
- If labs are necessary, additional testing and billing options will be discussed at the time the patient receives the lab.

Will I need supplements, and if so, how long will I have to be on these supplements? _____ **(initial)**

- Most patients with nutritional health concerns will have supplements recommended. Each supplement is chosen for the patient for a specific reason based upon the symptoms described to the doctor, as well as the results of any lab testing. The doctor will get into further details about the supplements ordered for you at your second appointment.
- The intent is always for the patient to eventually lessen the number and/or dosage of supplements, but the timeline for this is different for each patient and is based upon the improvement of the patient's condition over time. Often improvements are seen by 3-6 months and again at 9-12 months, however, results may take longer if patient fails to implement the dietary recommendations. Due to quality control, all supplements are non-refundable.

What happens after my new patient appointment? _____ **(initial)**

- After we receive your test results, we will call you to set up your next appointment. At this appointment, the doctor will go over your test results, your plan of care, and give you an estimate for length of care.
- The billing department will meet with you to discuss financial aspects and discounted plans.

I'm only here for chiropractic. What happens next? _____ **(initial)**

- Based on your signs and symptoms, X-rays may need to be completed as well as orthopedic testing. After the first few appointments, you will receive a doctor's report. The doctor's report will include information about your x-rays and a recommended plan of care. Adjustments will begin within the first few appointments. At this point, if you would like, you can speak with a member of our billing department about chiropractic care plans.

We look forward to seeing you at your new patient appointment soon, and we are excited to work with you to help you achieve optimal health. Please print your name, sign below, and bring this letter to your new patient appointment.

_____ _____

Printed Name Signature

Sincerely,

The Doctors and Staff of Revolution Health Center - A Wellness Way Affiliate

Terms of Acceptance

When a person seeks Chiropractic care and we accept a person 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 person understand both the objective and the method that will be used to attain it. This will prevent confusion.

Adjustment: A specific application of forces to facilitate the body's correction of the vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

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

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spine resulting in nerve dysfunction, resulting in the lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease other than the vertebral subluxation. However, if we encounter non-chiropractic or unusual findings we will advise you. If you desire advice, diagnoses or treatment for those findings we recommend that you seek another healthcare provider.

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 locate, analyze and correct vertebral subluxation by specific adjustments.

I, _____ have read and fully understand the above statements.
(Print name)

All questions regarding the chiropractor's objective to my care in his office have been answered to my complete satisfaction. I therefore accept care on this basis.

Signature: _____ Date: _____

CONSENT TO EVALUATE AND ADJUST A MINOR CHILD

I, _____ being the parent or legal guardian of _____
Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive Chiropractic care.

If you agree, sign below.

Signature: _____ Date: _____

PREGNANCY RELEASE

This is to certify that to the best of my knowledge I am not pregnant and the doctors and staff of Revolution Helath Center have my permission to perform x-ray(s). I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual period:_____

Signature: _____ Date: _____

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree with those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Signature of Patient Date

Identification of Persons with Authorization of Access to Patient Health Information

Those individuals or parties that could have access to Patient Health Information at **The Wellness Way Largo** include but may not be limited to the staff and contractors of The Wellness Way and the staff and contactors of The Wellness Way Clinics.

Please provide the necessary health care providers or persons who may need to be consulted if related to the patient's condition. They include:

1. _____
2. _____
3. _____
4. _____

Nutritional Informed Consent

According to the Federal Food, Drug and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean: *"Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease."*

A vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy.

Although a Vitamin, a Mineral, Trace Element, Amino Acid, or Herb may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone.

Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as any primary treatment and or therapy for any disease or particular bodily symptom.

Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and bio-mechanical processes of the human body.

I have read and understand the above information:

_____ _____

Signature Date

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at **Revolution Health Center** have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____ ☐ *Witness Initials*

Patient or Authorized person's Signature Date

REGARDING: X-rays/Imaging Studies

FEMALES ONLY → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-____ Date

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____ ☐ *Witness Initials*

Patient or Authorized person's Signature Date

Revolution Health Center *NOTICE REGARDING YOUR RIGHT TO PRIVACY and OFFICE POLICIES*

I have been offered a copy of Revolution Health Center's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received. This signature below is recognized by me as the signature page and will be retained by the practice as evidence of my receiving and understanding this 'Notice'.

Also, I hereby acknowledge that I have been offered a copy of the practices 'Office Policies'. I am aware that a more comprehensive version of the "Office Policies" is available to me and several copies kept in the reception area. This signature below is recognized by me as the signature page and will be retained by the practice as evidence of my receiving and understanding the "Office Policies'. I further acknowledge that any concerns regarding these 'Policies 'as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.

_____ _____ _____

Patient's Name DOB HR#

_____ _____

Patient signature Date

_____ _____

Witness Date

JDD,DC 5/2011