NEW PATIENT HEALTH HISTORY FORM

RiverOne
HEALTH & WELLNESS

In Order to provide you with the best care and reach accurate diagnosis, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

PATIENT DATA

Personal Information

Name: ____________________ , ____________________ (LAST / FIRST / MIDDLE INITIAL) DOB: ____________ (MM / DD / YYYY) SSN#: ______________ Gender: ☐ Male ☐ Female

Address: ________________________________ (STREET / CITY / STATE / ZIP) Occupation: ______________

Phone: ______________ ______________ ______________ (MOBILE / HOME / WORK) Email: ______________

Marital Status: ☐ Married ☐ Single ☐ Widow ☐ Divorced Spouse/Partner Name: ______________ (IF APPLICABLE) # of Children: ______ (IF APPLICABLE)

Employer

Name: ________________________________

Address: ________________________________ (STREET / CITY / STATE / ZIP) Phone: ______________

Emergency Contact

Name: ______________________ Phone: ______________ Relationship: ______________

How did you find out about us? Whom may we thank for refferring you to this office: ______________

Have you had previous chiropractic care? ☐ Yes ☐ No Have you had previous acupuncture care? ☐ Yes ☐ No

Describe your experience: ________________________________

ACCIDENT INFORMATION

Is condition due to accident? ☐ Yes (Date of accident: ____________) (MM / DD / YYYY) ☐ No

If yes, Type of Accident: ☐ Auto ☐ Work ☐ Home ☐ Other: ______________ (ex) Illness, Gradual onset, Unknown cause)

Where have you made a report of the accdient? ☐ Auto insurance ☐ Employer ☐ Worker's Comp

Attorney (If applicable)

Name: ______________________ Phone: ______________ Claim Number: ______________

INSURANCE INFORMATION

Primary Insured Name: ______________________ Relationship to Patient: ______________

Insurance Company: ______________ ID#: ______________ Group # / Name: ______________

Secondary Insurance Information (If applicable)

Secondary Insured Name: ______________________ Relationship to Patient: ______________

Insurance Company: ______________ ID#: ______________ Group # / Name: ______________

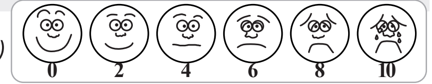
NEW PATIENT HEALTH HISTORY FORM

Patient Name:____

RiverOne
HEALTH & WELLNESS

PATIENT CONDITION

• Describe your present major complaints: *(Rating pain on a scale of 1-10 with 10 being highest)*



1. ____ _____/10
2. ____ _____/10
3. ____ _____/10

• When does the symptoms get worse? ☐ Morning ☐ Afternoon ☐ Night

• How did your symptoms occur?______________________________ Date Occurred:__________ MM / DD / YYYY

• Type of Pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other:______________________________

• Muscle weekness? ☐ Yes - *Where?(arm, leg, etc.)*____________________________ ☐ No

• Numbness or tingling? ☐ Yes - *Where?(hand, feet, etc.)*____________________________ ☐ No

• Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and Goes ☐ Not Sure

• Is this condition interfering with the following?
☐ work ☐ Sleep ☐ Daily Routine ☐ Not Sure
☐ Other:______________________________

• Symptoms have persisted for (number):
____Hours ____Days ____Weeks ____Months ____Years

Check all activities that **AGGRAVATE YOUR CONDITION**:

☐ Bending ☐ Reaching ☐ Lifting ☐ Sitting
☐ Lying ☐ Standing ☐ Walking ☐ Sneezing
☐ Coughing ☐ Turning ☐ Straining at stool
☐ Other______________________________

Check all activities that **RELIEVE YOUR CONDITION**:

☐ Bending ☐ Reaching ☐ Lifting ☐ Lying
☐ Sitting ☐ Stretching ☐ Standing ☐ Walking
☐ Turning ☐ Self Massage ☐ Cold Pack ☐ Hot Pack
☐ Other______________________________

• Have you been treated by other doctors for the above conditions? ☐ Yes ☐ No
If yes, please list doctor's name and type of treatments:

____

____

____

• List any complaint of previous care:____________________

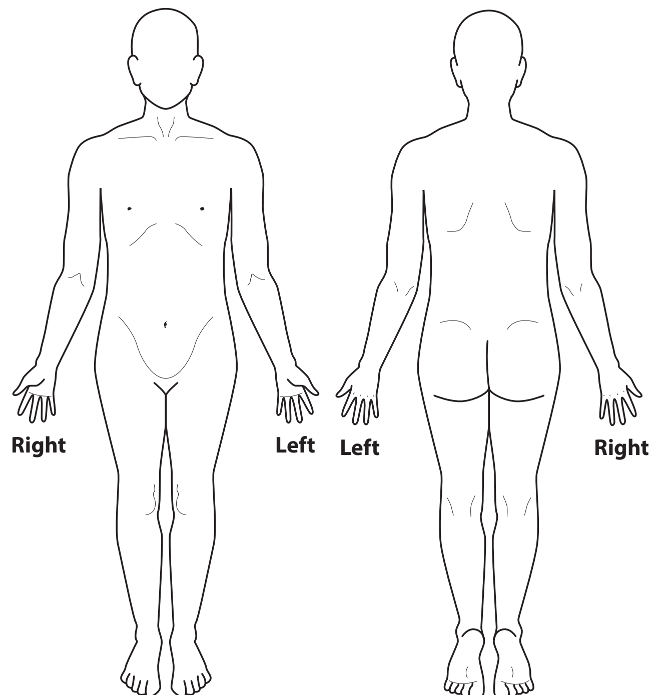
____

____

PAIN DRAWING

Mark your painful spots on the picture. If your pain radiates, draw an arrow from where it starts to where it stops. Use the appropriate symbols to describe the pain.

Symbol	Description	Symbol	Description
> > >	Ache	o o o	Tingling
x x x	Burning	/ / /	Stabing
= = =	Numbness	~ ~ ~	Throbbing



NEW PATIENT HEALTH HISTORY FORM

RiverOne HEALTH & WELLNESS

Patient Name:____

PAST MEDICAL, SOCIAL AND FAMILY HISTORY

Family Physician____________________ Phone____________ Last physical examination________ MM / DD / YYYY

Describe any MRI taken:____________________________ Date:__________

Describe any CT Scan taken:____________________________ Date:__________

Describe any X-ray taken:____________________________ Date:__________

List blood test or urinalysis by type and date:____________________________

Accidents/Injuries

Have you ever been in an auto accident? ☐ Past Year ☐ Past 5 Years ☐ Over 5 Years ☐ Never

Describe:____________________________

Please list all other injuries/surgeries you have had:

	Falls	Head Injuries	Broken Bones	Dislocations	Surgeries
Description					
Date					

Medications/Supplements

List medicines and supplements you take and the reason you take them:

1. ____________________ 4. ____________________

2. ____________________ 5. ____________________

3. ____________________ 6. ____________________

Are you allergic to any medications? ☐ Yes ☐ No If yes, what kind?________________

List any other allergy:____________________________

Habits (note daily amount)

Sleep ________ Tobacco ________ Coffee ________ Tea ________ Alcohol ________

Recreational drug use ________ Other ____________________

Activities (note type and time spent doing activity)

Exercise ____________________________

Hobbies____________________________

Nutrition

How many meals do you eat a day?______ Are you happy with your nutritional state? ☐ Yes ☐ No

Other Health Concerns

Have you been treated/evaluated for any health condition by a physician in the last year? ☐ Yes ☐ No

If yes, what condition?____________________________

FAMILY HEALTH HISTORY

List any family history of diseases: ____________________________

ex) Diabetes, Thyroid Disease, Stroke, Kidney Disease, High Blood Pressure, Heart Disease, Cancer (Type), Obesity, Allergies, psychiatric disorder, etc.

FOR OFFICE USE ONLY:

I have reviewed the above past medical, social & family history with the above named patient:

Doctor Signature ____________________ Date __________

REVIEW OF SYSTEMS

Patient Name:____

RiverOne HEALTH & WELLNESS

INSTRUCTIONS: Please fill out all of the sections. If none of the conditions apply, select "None

Constitutional:
- ☐ **None**
- ☐ Chills
- ☐ Daytime Drowsiness
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats
- ☐ Weight Gain
- ☐ Weight Loss

Eyes/Vision:
- ☐ **None**
- ☐ Blindness
- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Change in Vision
- ☐ Double Vision
- ☐ Eye Pain
- ☐ Field Cuts
- ☐ Glaucoma
- ☐ Itching *(around the eyes)*
- ☐ Phtophobia
- ☐ Tearing
- ☐ Wears Glasses or Contacts

Ears, Nose and Throat:
- ☐ **None**
- ☐ Bleeding Dental Implants
- ☐ Dentures
- ☐ Difficulty Swallowing
- ☐ Discharge
- ☐ Dizziness
- ☐ Ear Drainage
- ☐ Ear Infection(s)
- ☐ Ear Pain
- ☐ Fainting
- ☐ Headaches
- ☐ Head Injury *(history of)*
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Loss of Smell
- ☐ Nasal Congestion
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Rhinorrhea *(runny nose)*
- ☐ Sinus Infections
- ☐ Snoring
- ☐ Sore Throats
- ☐ Tinnitus (ringing in the ears)
- ☐ TMJ Disorder

Cardiovascular:
- ☐ **None**
- ☐ Angina *(chest pain or discomfort)*
- ☐ Chest Pain
- ☐ Claudication *(leg pain or achiness)*
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Orthopnea *(difficulty breathing while lying)*
- ☐ Palpitations *(irregular or forceful heart beat)*
- ☐ Paroxysmal Nocturnal Dyspnea *(shortness of breath at night)*
- ☐ Shortness of Breath
- ☐ Swelling of Leg*(s)*
- ☐ Ulcers
- ☐ Varicose Veins

Gastrointestinal:
- ☐ **None**
- ☐ Abdominal Pain
- ☐ Belching
- ☐ Black, Tarry Stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty Swallowing
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Jaundice *(yellowing of the skin)*
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Abnormal Stool Caliber *(quality)*
- ☐ Abnormal Stool Color
- ☐ Abnormal Stool Consistency
- ☐ Vomiting
- ☐ Vomiting Blood

Respiration:
- ☐ **None**
- ☐ Asthma
- ☐ Coughing up Blood
- ☐ Shorness of Breath
- ☐ Sputum Production
- ☐ Wheezing

Endocrine:
- ☐ **None**
- ☐ Cold Intolerance
- ☐ Diabetes
- ☐ Excessive Appetite
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Frequent Urination
- ☐ Goiter
- ☐ Hair Loss
- ☐ Heat Intolerance
- ☐ Unusual Hair Growth
- ☐ Voice Changes

Skin:
- ☐ **None**
- ☐ Changes in Nail Texture
- ☐ Changes in Skin Color
- ☐ Hair Growth
- ☐ Hair Loss
- ☐ Hives
- ☐ Itching
- ☐ Paresthesia *(numbness, prickling, or tingling)*
- ☐ Rash
- ☐ History of Skin Disorders
- ☐ Skin Lesions or Ulcers
- ☐ Varicosities

Nervous System:
- ☐ **None**
- ☐ Dizziness
- ☐ Facial Weakness
- ☐ Headaches
- ☐ Limb Weakness
- ☐ Loss of Consciousness
- ☐ Loss of Memory
- ☐ Numbness
- ☐ Seizures
- ☐ Sleep Disturbance
- ☐ Slurred Speech
- ☐ Stress
- ☐ Strokes
- ☐ Tremors
- ☐ Unsteadiness of Gait

Allergy:
- ☐ **None**
- ☐ Anaphylaxis *(history of)*
- ☐ Food Intolerance
- ☐ Itching
- ☐ Nasal Congestion
- ☐ Sneezing

Hematology:
- ☐ **None**
- ☐ Anemia
- ☐ Bleeding
- ☐ Blood Clotting
- ☐ Blood Transfusion*(s)*
- ☐ Bruises easily
- ☐ Fatigue
- ☐ Lymph Node Swelling

Psychological:
- ☐ **None**
- ☐ Anhedonia *(inability to experience joy or enjoy life)*
- ☐ Anxiety
- ☐ Appetite Changes
- ☐ Behavioral Changes*(s)*
- ☐ Bipolar Disorder
- ☐ Confusion
- ☐ Convulsions
- ☐ Depression
- ☐ Insomnia
- ☐ Memory Loss
- ☐ Mood Change*(s)*

Female:
- ☐ **None**
- ☐ Birth Control Therapy
- ☐ Breast Lumps / Pain
- ☐ Burning Urination
- ☐ Cramps
- ☐ Frequent Urination
- ☐ Hormone Therapy
- ☐ Irregular Menstruation
- ☐ Urine Retention
- ☐ Vaginal Bleeding
- ☐ Vaginal Discharge

Male:
- ☐ None
- ☐ Burning Urination
- ☐ Erectile Dysfunction
- ☐ Frequent Urination
- ☐ Hesitancy or Dribbling
- ☐ Prostate Problems
- ☐ Urine Retention

Patient Signature: ____

FOR OFFICE USE ONLY:

I have reviewed the above ROS with the above named patient: ____________________________ ____________

Doctor Signature Date

FINANCIAL AGREEMENT

RiverOne
HEALTH & WELLNESS

Patient Name:____

I hereby acknowledge and agree to the financial policies of RiverOne Health & Wellness LLC for any healthcare services rendered to me. By signing below, I agree to the following terms:

RELEASE OF INFORMATION: I authorize the release of any information concerning my health and healthcare services to my insurance companies or Medicare.

ASSIGNMENT OF BENEFITS: I authorize and direct that payment be made directly to RiverOne Health & Wellness LLC for any and all insurance benefits or reimbursement for services rendered by him, which amounts otherwise be payable to me under any insurance.

PAYMENT AGREEMENT: I understand that there is no guarantee that my insurance companies 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. All deductibles and co-payments are due at the time of service. I understand that if I do not have insurance, I will be responsible for full payment at the time of service. For your convenience, credit cards, debit cards, or HSA accounts can be applied toward payment. If you are unable to pay the entire balance, payment arrangements can be made. Please contact our office.

CANCELLATION POLICY/NO SHOW POLICY FOR ALL APPOINTMENTS: I understand and agree to RiverOne Health & Wellness LLC's cancellation and no-show policy for all appointments. Failure to provide adequate notice for adjustments and cancellations will result in the following fees charged to your card or billed to you:
- Notification given at least 24 hours before your appointment: No charges.
- Notification given less than 24 hours before your appointment: A flat rate charge of $40.
- Failure to show up for your appointment: Full charge of the reserved service amount.

BILLING: I understand that RiverOne Health & Wellness LLC will bill my insurance company directly for services rendered. However, it is my responsibility to ensure that RiverOne Health & Wellness LLC has accurate and up-to-date insurance information. If RiverOne Health & Wellness LLC is unable to bill my insurance company, they will bill me directly for the services provided.

DELINQUENT ACCOUNTS: In the event that my account becomes delinquent, RiverOne Health & Wellness LLC reserves the right to turn the account over to a collection agency such as Capital Accounts. If my account is turned over to a collection agency, I will be responsible for any collection fees and/or legal fees that may be incurred.

CREDIT CARD AUTHORIZATION AND AGREEMENT: By signing this form, I authorize RiverOne Health & Wellness to charge my credit card immediately for any applicable fees, including copays, deductibles, cancellation fees, no-show fees, and any outstanding balances. Charges will be processed at the time of service. I understand that my credit card information, including the cardholder name, card type, card number, expiration date, and CVV, will be securely stored and used for these transactions. It is my responsibility to provide RiverOne Health & Wellness with my most up-to-date phone number and email address. If my card has insufficient funds and payment is not made within 60 days, I acknowledge that my account may be sent to a collections agency. I have read and understand the terms and conditions of this agreement.

I have read and understand the financial policies of RiverOne Health & Wellness LLC and agree to comply with them. I also understand that these policies may be revised from time to time, and that I will be notified of any changes.

Patient Signature ______________________________________ Date ______________

Signature ______________________________________ Date ______________
(Responsible party if under 18)

NOTICE OF PRIVACY PRACTICES (HIPAA NOTICE)

RiverOne HEALTH & WELLNESS

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record: You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record: You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications: You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share: You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-packet in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information: You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice: You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically, we will provide you with a paper copy promptly.

Choose someone to act for you: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated: You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877- 696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints. We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to: Share information with your family, close friends, or others involved in your care. Share information in a disaster relief situation. Include your information in a hospital directory. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission: Marketing purposes. Sale of your information. Sharing of psychotherapy notes.

In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again.

Initial:________

OUR USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways:

Treat you: We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization: We can use and share your health information to run our practice, improve your care, and contact your when necessary. Example: We use health information about you to manage your treatment and services.

Bill for your services: We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/ understanding/consumers/index.html.

Help with public health and safety issues: We can share health information about you for certain situations such as preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, preventing or reducing a serious threat to anyone's health or safety.

Do research: We can use or share your information for health research.

Comply with the law: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests: We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests: We can use or share health information about you for worker's compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, for special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions: We can share heath information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities
We are required by law to maintain to privacy and security of your protected health information.
We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
We must follow the duties and privacy practices described in this notice and give you a copy of it.
We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of This Notice: We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request.

Additional Items: 1) Open Room: We utilize an open adjusting therapy room. We make good faith attempts to keep our conversations at a low level. We offer every patient the opportunity to be treated in a private room if requested.

Contact information:
Should you wish to contact the HIPAA Compliance Officer, you may do so at the address and telephone number below.
HIPAA Compliance Officer
370 Houbolt Rd., Joliet, IL 60431 | T: (815)705-6246 | E: info@riveronehealth. com

Initial:_______

PATIENT ACKNOWLEDGMENT OF HIPAA NOTICE

RiverOne
HEALTH & WELLNESS

Notice to Patient:

We are required to offer you a copy of our HIPAA notice which states how we may use and/or disclose your health information. Our HIPAA notice and office policies contain information regarding payment, health insurance, collections and other important information.

Patient Acknowledgment:

I acknowledge and agree to this office's HIPAA notice. I acknowledge that I have reviewed the HIPAA notice and have the right to obtain a paper copy of the HIPAA notice. I acknowledge that I may refuse to sign this acknowledgment if I wish.

____
Patient Printed Name

____
Patient Signature or legal representative

____
If legal representative, state relationship

____
Date

FOR OFFICE USE ONLY:

We have made every effort to obtain written acknowledgment of receipt of our HIPAA notice from this patient but it could not be obtained because:

___ the patient refused to sign
___ we were not able to communicate with the patient
___ due to an emergency situation it was not possible to obtain a signature
___ other (please provide details): ______________________________

____
Name of Patient

____
Name of Staff Member

____
Signature of Staff Member

____
Date

INFORMED CONSENT TO CARE

RiverOne
HEALTH & WELLNESS

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: ____________________ Signature: ____________________ Date: __________

Parent or Guardian: ____________________ Signature: ____________________ Date: __________

Witness Name: ____________________ Signature: ____________________ Date: __________

INFORMATION AND INFORMED CONSENT FOR ACUPUNCTURE TREATMENT

RiverOne
HEALTH & WELLNESS

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, blistering, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising and blistering are common side effects of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Acupuncturist Name: Dr. Ha-il Lee *DC, LAc, Dipl OM, MSOM*

Patient Signature ____________________ ____________________ Date ____________
(or Responsible Authority) *(Indicate relationship if signing for patient)*