BURTON HEALTH & WELLNESS, LLC

CODY A. BURTON, D.C.

DATE: ____/_____/_____

PATIENT INFORMATION:

PATIENT NAME: _____ **DATE OF BIRTH:** ___/____/_____

ADDRESS: _____ **CITY** _____ **STATE** _____ **ZIP** _____

CELL PHONE: _____ **HOME PHONE**: _____

EMAIL: _____ **OCCUPATION**: _____

EMERGENCY CONTACT: _____ **RELATIONSHIP**: _____

CONTACTS PHONE NUMBER: _____

REFFERAL SOURCE: _____

COMPLETE IF PATIENT IS A MINOR:

RESPONSIBLE PARTY NAME:_____ **DATE OF BIRTH**:____/____/____

ADDRESS:_____ **CITY**_____ **STATE**_____ **ZIP**_____

CELL PHONE:_____ **HOME PHONE:**_____

E-MAIL: _____

PATIENT HEALTH HISTORY:

LIST ANY ALLERGIES: _____

LIST ANY SURGERIES: _____

_____

ARE YOU TAKING ANY OF THE FOLLOWING (circle all that apply):

NERVE PILLS PAIN KILLERS BLOOD THINNERS MUSCLE RELAXERS DIABETES MEDICINE
CHOLESTEROL MEDICINE TRANQUILIZERS HIGH/LOW BLOOD PRESSURE MEDICINE

PLEASE LIST ALL MEDICATIONS: _____

_____

_____

ANY ARTIFICIAL BONES OR JOINTS: _____

FOR WOMEN:

ARE YOU PREGNANT: YES NO **ARE YOU NURSING**: YES NO **ON BIRTH CONTROL**: YES NO

EXERCISE:	WORK ACTIVITY:	HABITS:	
○ NONE	○ SITTING	○ SMOKING	PACKS/DAY _____
○ MODERATE	○ STANDING	○ ALCOHOL	DRINKS/WEEK _____
○ DAILY	○ LIGHT LABOR	○ COFFEE/CAFFINE	DRINKS/DAY _____
○ HEAVY	○ HEAVY LABOR	○ HIGH STRESS LEVEL	REASON: _____

PATIENT CONDTION:

REASON FOR VISIT: _____

WHEN INJURY OCCURED: _____**CAUSE OF INJURY**: _____

IS YOUR CONDITION GETTING WORSE: NO YES **RATE YOUR PAIN FROM 0(no pain) to 10(severe pain)** _____

TYPE OF PAIN (circle all that apply): TIGHT SHARP ACHE NUMB BURN OTHER:_____

PAIN RADIATES TO: _____ **PAIN IS:** CONSTANT COMES AND GOES

WHAT MAKES CONDITION WORSE: STANDING SITTING LAYING MOVEMENT OTHER:_____

WHAT MAKES CONDITION BETTER: ICE HEAT STRETCHING PAIN RELIEVERS OTHER: _____

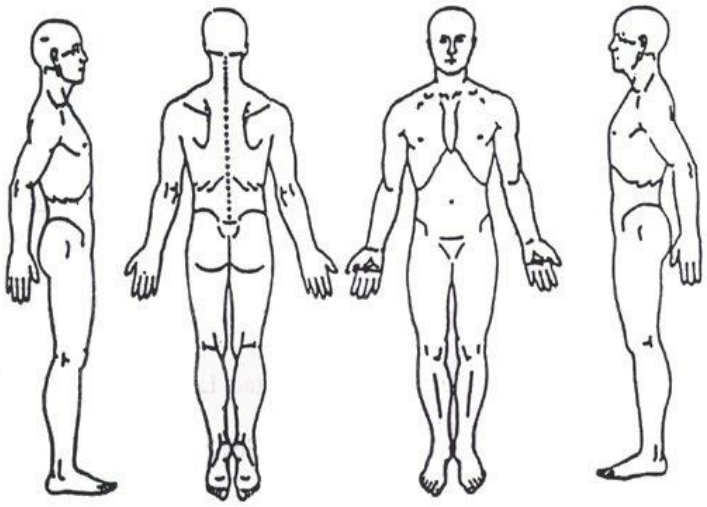
DOES IT INTERFERE WITH: WORK SLEEP DAILY ROUTINE RECREATION

LAST ADJUSTMENT: _____ **CLINIC OR DOCTOR:** _____

LAST MRI: _____ **LAST CT SCAN:** _____ **LAST X-RAY:** _____

INERESTED IN (circle all that apply): CHIROPRACTIC ACUPUNCTURE NUTRITION

CIRCLE ANY AREAS AFFECTED:



REVIEW OF SYSTEMS

Please check if you are currently experiencing any of the following symptoms. Please check **NONE** if you are not.

GENERAL
- **NONE**
- Chills
- Convulsions
- Fainting
- Fatigue
- Fever
- Loss of sleep
- Nervousness
- Sweats
- Weight Loss
- Weight Gain

MUSCLE & JOINT
- **NONE**
- Arthritis
- Bursitis
- Low Back Pain
- Neck Pain/Stiffness
- Pain between Shoulder Blades
- Painful Tailbone
- Poor Posture
- Sciatica
- Spinal Curvature
- Swollen Joints
- Pain or Numbness in:
  - Shoulder
  - Arm
  - Elbow
  - Hands
  - Hips
  - Legs
  - Knees
  - Feet

GASTROINTESTINAL
- **NONE**
- Belching or Gas
- Colitis
- Colon Problems
- Constipation
- Diarrhea
- Excessive Hunger
- Gall Bladder Problems
- Hemorrhoids
- Intestinal Worms
- Jaundice
- Liver Problems
- Nausea
- Pain over Stomach
- Poor appetite
- Vomiting
- Vomiting Blood

RESPIRATORY
- **NONE**
- Chronic Cough
- Difficulty Breathing
- Shortness of Breath
- Spitting up Blood
- Spitting up Phlegm
- Wheezing

NEUROLOGICAL
- **NONE**
- Dizziness/Vertigo
- Headaches
- Loss of Balance
- Migraines
- Stroke
- Tremors

EARS, NOSE & THROAT
- **NONE**
- Deafness
- Earache
- Ear Discharge
- Ear Noises / Tinnitus
- Enlarged Glands
- Enlarged Thyroid
- Hay Fever
- Hoarseness
- Nasal Obstruction
- Sinus Infection
- Sore Throat
- Tonsillitis

SKIN
- **NONE**
- Boils
- Bruise Easily
- Dryness
- Hives
- Itching
- Rash

Cardiovascular
- **NONE**
- Chest Pain
- Hardening of Arteries
- High Blood Pressure
- Low Blood Pressure
- High Cholesterol
- High Triglycerides
- Poor Circulation
- Rapid Heartbeat
- Slow Heartbeat
- Swelling in Ankles

EYES
- **NONE**
- Blurry Vision
- Double Vision
- Dry Eyes
- Eye Discharge
- Eye Pain
- Eye Redness
- Failing Vision

Psychiatric
- **NONE**
- Anxiety
- Depression
- Panic Attacks
- Alcohol/Drug Dependence

GENITOURINARY
- **NONE**
- Bed Wetting
- Blood in Urine
- Frequent Urination
- Kidney Infection
- Painful Urination
- Prostate Problems
- Pus in Urine

WOMEN ONLY
- **NONE**
- Congested Breasts
- Cramps or Backache
- Excessive Menstrual Flow
- Hot Flashes
- Irregular Cycle
- Menopausal Symptoms
- Painful Menstruation
- Vaginal Discharge

Please describe/explain any treatment you have had or are currently receiving for the symptoms checks above. Please also note any other health problems you have that may not have been covered on this form.

_____

_____

_____

Burton Health and Wellness, LLC

Informed Consent
Chiropractic, Acupuncture Treatment and Nutrition Support

Chiropractic Treatment

The nature of chiropractic treatment: The doctor of chiropractic will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop," such as the noise of a knuckle that 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 dry hydrotherapy may also be used.

Possible risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves, or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Possibility of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare," about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to on in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare."

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

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

-*Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs included a multitude of undesirable side effects and patient dependence in a significant number of cases.

-*Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.

-*Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, 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 difficulty.

Unusual risks: I have had the above unusual risks explained to me. I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions 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.

Acupuncture Treatment

The nature of needle acupuncture treatment: Acupuncture involves the insertion of thin needles through your skin at strategic points on your body by a practitioner certified in acupuncture techniques.

Possible risks: As with any health care procedure, complications are possible following needle acupuncture treatment. Complications could include: minor pain or soreness in the treatment areas that may last up to a few days, temporary bruising / swelling, sensations of heat / cold / tingling or numbness, skin irritation or slight bleeding at needle site, generalized fatigue and/or temporary aggravation of symptoms. Rare side effects to acupuncture treatment may include infection at needle site, needle sickness (dizziness, nausea, fainting), broken needles, pneumothorax.

Disclosure: I agree to contact my practitioner immediately if I experience any problem which I associate with the treatments listed above and will seek immediate help from a physician / hospital if I experience a medical emergency. During the course of treatment, I agree to inform my acupuncturist of all health issues and medication changes.

PREGNANCY: I will notify my acupuncturist should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid points that could induce premature labor or miscarriage.

I understand that Burton Health and Wellness, LLC uses only sterile, disposable, one-time-use needles.

Nutrition Support

Nutrition consults at Burton Health and Wellness, LLC can provide information and guidance about health factors within my own control: my diet, nutrition, and lifestyle. I understand that Dr. Cody Burton is a Chiropractor and can provide education to enhance my knowledge of health through the use of whole foods and dietary supplements. While nutritional and botanical support can be an important compliment to my medical care, I understand these services are not a substitute for medical care. Methods of nutritional evaluation or testing made available to me are not intended to diagnose disease. Rather, these assessment tests are intended as a guide to developing an appropriate health-supportive program for me, and to monitor my progress in achieving my goals.

Consent to Treat

I have the legal right to consent to chiropractic, acupuncture treatment and nutrition support because (a) I am the patient or (b) I am the parent/guardian of the patient. All references to "patient", "me" and "my" in this document means: _____(name of patient).

I voluntarily authorize and consent to the chiropractic treatment, acupuncture, and nutrition support and diagnostic tests that the provider at Burton Health and Wellness, LLC and their designated associates or assistants believe are necessary. I understand that by signing this form, I am giving permission to the chiropractor and other health care providers in this office to provide treatment as long as a chiropractor/patient relationship exists, or until I withdraw my consent. _____ (Please initial)

Voicemail, Email and Text Notifications

As a service to our patients, Burton Health and Wellness, LLC may provide courtesy appointment reminder calls/texts/email and possibly other important calls that may be placed using a prerecorded auto messaging system. The information may include protected health information. By initialing below, you consent to receiving such calls/texts/emails at the cell phone number and/or email address you have provided to us._____ (Please initial)

Acknowledgment: Notice of Privacy Practices

I have reviewed and understand Burton Health and Wellness, LLC's Notice of Privacy Practices ("Notice"). The Notice explains how Burton Health and Wellness, LLC may use and disclose the patient's protected health information for treatment, payment and health care operations purpose. "Protected health information" means the patient's personal health information found in the patient's medical and billing records. If you have questions about the Notice, please contact Burton Health and Wellness, LLC's Privacy Officer at (979) 732-3900. _____ (Please initial). I understand that I am entitled to a copy of this document and that copies are available at Burton Health and Wellness, LLC office.

I have read this form or this form has been read to me in a language that I understand, and I have had an opportunity to ask questions about it. _____ (Please initial)

Patient's Name: _____Date of birth (MM/DD/YYYY):_____

Name of Patient's Representative, if patient under 18 (Printed): _____

Relationship of Patient's Representative, if patient is under 18: _____

Signature of Patient or Patient's Representative: _____

Date: _____

Updated October 19, 2017

Notice of Privacy Policies

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices applies to Burton Health and Wellness, LLC. Its professional staff, employees and volunteers follow the privacy practices described in this Notice – effective January 1, 2015.

Your Health Information 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. Forms are available on our website: www.burtonchiro.com, or by contacting the privacy officer at Burton Health and Wellness, LLC at 979-732-3900.

- A copy of this Notice. You can ask for a paper copy of this notice at any time. Paper copies of this notice may be obtained from the front desk at Burton Health and Wellness, LLC. You may obtain an electronic copy of this notice on our web site, www.burtonchiro.com.
- Get a paper copy of your medical record or health and claims record. You can ask to see or get a paper copy of your medical record or health and claims records and other health information we have about you. Burton Health and Wellness, LLC may charge you a reasonable, cost-based fee for copying your information. You must make this request in writing.
- Ask us to correct your medical record or your health and claims records. You can ask us to correct your health information or health and claims records if you think they are incorrect or incomplete. We may say "no" to your request, but we'll tell you why in writing within 60 days. You must make your request in writing and you must provide a reason for the request.
- 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 other operations. If you personally pay in full for an item or service or someone other than your health plan pays in full for the item or service on your behalf, 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" if you have already paid in full for the item or service unless a law requires us to share that information. Otherwise, we are not required to agree to your request, and we may say "no" if it would affect your care.
- 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. Burton Health and Wellness will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not. You must make this request in writing and you must tell us how or where you wish to be contacted.
- 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, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, or health care operations, or certain other disclosures (such as any you asked us to make). We will include each disclosure we made for the past six (6) years, unless you request a shorter time period. We will provide one accounting a year for free but will charge you a reasonable, cost-based fee if you ask for another within 12 months.
- 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 our privacy officer at 979-732-3900. You can also file a complaint with the United States 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/. You will not be penalized or retaliated against in any way for filing a complaint. We will not require you to waive your right to file a complaint as a condition of the provision of treatment or payment.

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 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

We may share your information when needed to lessen a serious and imminent threat to health or safety. We never share your information for marketing purposes unless you give us written permission.

Our Uses and Dislcosures:

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

- **Treat you.** We can use your health information and share it with other professionals who are treating you. We may share your health information with people outside Burton Health and Wellness, LLC who may be involved with your medical care, such as other health care providers physical therapy organizations, x-ray technitions (verbal, fax, mail or electronic).
- **Payment.** We can use and share your health information to bill and get payment from your insurance company or a third party. For example, we may need to provide your health plan with information about the treatment you received so that your health plan will pay us or reimburse you for the treatment. Also, we may share your health information with your other health care providers to assist those providers in obtaining payment from your insurance company or a third party.
- **Run our organization**. We can use and share your health information to run our organization, improve your care, and contact you when necessary. For example, we use health information about you to manage your treatment and services to improve our services.
- **Business Associates**. We can share your health information with our business associated for any of the purposes listed above. **Electronic.** We may share your information electronically.

How else can we use or share your health information: We are allowed or required to share your information in other ways – usually ways that contribute to the public good, such as public health.

- 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 births and deaths; reporting suspected abuse, neglect, or domestic violence; reporting reactions to supplements or creams or product problems; or preventing or reducing a serious threat to anyone's health or safety.
- 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.
- Address workers' compensation, law enforcement, or other governmental requests. We can use or share health information about you: for workers' compensation claims; for law enforcement purposes or with law enforcement official or correctional institution; with health oversight agencies for activities authorized by law; or for special government functions, such as military, national security, and presidential protective services.
- Respond to lawsuits and legal actions. We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Burton Health and Wellness, LLC's Responsibilities

We are required by law to maintain the 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 will not sell 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. An authorization form and Revocation of Authorization form are available by contacting Burton Health and Wellness, LLC's privacy officer at 979-732-3900.

Changes to 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, in our office. This notice is effective January 1, 2015.

Contact

If you have any questions about this Notice or your privacy rights, or wish to obtain a form to exercise your rights as described above, you may contact Burton Health and Wellness, LLC's privacy officer at 979-732-3900.

Acknowledgement of Privacy Practices

Written Acknowledgement of Receipt of Burton Health and Wellness, LLC's Notice of Privacy Practices

By signing below, you acknowledge receiving the Burton Health and Wellness, LLC's Notice of Privacy Practices (Notice). The Notice explains how Burton Health and Wellness, LLC may use and disclose your protected health information for treatment, payment and healthcare operations purposes. Protected health information means your personal health information found in your medical and billing records.

Burton Health and Wellness, LLC reserves the right to change the Notice from time to time. A copy of the current Notice or a summary of the current Notice will be posted at Burton Health and Wellness, LLC service locations. The effective date of the Notice will appear on the Notice summary. In addition, each time you are treated at Burton Health and Wellness, LLC, a copy of the current notice in effect, at your request, will be available to you.

Your signature below acknowledges that you have received this Notice.

If you have any questions about the Notice, please contact Burton Health and Wellness, LLC's privacy officer. Contact information is located in the notice.

Printed Name of Patient_____

Patient's Date of Birth_____

Printed Name of Patient's Representative_____

Relationship of Patient's Representative_____

Signature of Patient or Patient's Representative_____

Date_____