Authorization to Use or Disclose Protected Health Information

Peak Family Chiropractic, LLC

Patient Name:_____ Date:_____

Address:_____City:_____ State:_____ Zip:_____

Email:_____Home Phone Number:_____

Date of Birth:_____Cell Phone Number:_____

As required by the Privacy Regulations, Peak Family Chiropractic LLC may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associated of this office: **EMI (Electronic Medical Interpretations)**

Patient Health Information authorized to be disclosed: **Thermal images and related health history**

For the specific purpose of (describe in detail): **Interpretation of said images**

Effective dates for this authorization: ___/___/___ through ___/___/___
This authorization will expire at the end of the above period.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of the Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

_____ _____

Signature of Patient or Patient's Authorized Representative Date

_____ _____

Authorized Signature of Facility Date

All information given in the questionnaire will remain strictly confidential and will only be divulged to the reporting thermologist and any other practitioner that you specify.

PEAK FAMILY CHIROPACTIC, LLC
Breast Thermography Confidential Questionnaire

Patient Name: _____ **Date:** _____

		Yes	No
1.	Do you have any close relative who has had breast cancer?	☐	☐
2.	Have you ever been diagnosed with breast cancer?	☐	☐
3.	Have you ever been diagnosed with any other breast disease (i.e. fibrocystic)?	☐	☐
4.	Have you had any biopsies or surgeries to your breasts?	☐	☐
5.	Have you had any breast cosmetic surgery or implants?	☐	☐
6.	Have you had a mammogram in the past 12 months?	☐	☐
7.	Have you had a mammogram in the past 5 years?	☐	☐
8.	Have you had abnormal results from any breast testing?	☐	☐
9.	Have you ever taken a contraceptive pill for more than 1 year?	☐	☐
10.	Have you suffered with cancer of the womb?	☐	☐
11.	Have you had pharmaceutical hormone replacement therapy?	☐	☐
12.	Do you have an annual physical examination by a doctor?	☐	☐
13.	Do you perform monthly breast self-exam?	☐	☐
14.	How many mammograms have you had in total? _____		
15.	What was your age when you had your first mammogram? _____		
16.	How many births have you had? _____ Your age at birth of first child? _____		
17.	Did your periods start before the age of 12? _____ Or finish after the age of 50? _____		
18.	Do you smoke? (circle one) Yes Never Not in the last 12 months Not in the last 5 years		

Have you recently had any of these breast symptoms:	Right Breast	Left Breast
Pain	☐	☐
Tenderness	☐	☐
Lumps	☐	☐
Change in breast size	☐	☐
Areas of skin thickening or dimpling	☐	☐
Secretions of the nipple	☐	☐

PATIENT DISCLOSURE: I understand that the report generated from my images is intended for use by trained health care providers to assist in evaluation, diagnosis and treatment. I further understand that the report is not intended to be used by individuals for self-evaluation or self-diagnosis. I understand that the report will not tell me whether I have any illness, disease, or other condition, but will be an analysis of the images with respect only to the thermographic findings discussed in the report. By signing below, I certify that I have read and understand the statements above and consent to the examination.

_____ _____

Signature of Patient or Patient's Authorized Representative Date

Fill out only if you have previously been diagnosed with Breast Cancer:

PEAK FMILY CHIROPRACTIC, LLC
Extended Breast Questionnaire

Patient Name: _____ **Date:** _____

Date diagnosed with breast cancer: month: _____ year: _____

Cancer type: Metastatic: _____ Local: _____ Lymph Node Involvement: _____

Where (left breast): UO _____ UI _____ LO _____ LI _____ Nipple _____

Where (right breast): UO _____ UI _____ LO _____ LI _____ Nipple _____

Treatment (circle all that apply): Surgery Chemo Radiation Reconstruction Other None

Breast Biopsies or Surgery:

Where (left breast): UO _____ UI _____ LO _____ LI _____ Nipple _____

Where (right breast): UO _____ UI _____ LO _____ LI _____ Nipple _____

Diagnosed with other breast disease:

Disease type – RIGHT breast (circle all that apply): Fibrocystic Cystic Mastitis Abscess Other

Disease type – LEFT breast (circle all that apply): Fibrocystic Cystic Mastitis Abscess Other

General Patient Questionnaire

Please fill out as completely as possible. **If there is something that has no answer, please indicate by writing "none."**
Write an answer on every line. Do not leave anything blank.

Patient Name:_____ Date:_____

Address:_____City:_____ State:_____ Zip:_____

Email:_____Home Phone Number:_____

Date of Birth:_____ Age: _____ Cell Phone Number:_____

Gender: _____ Occupation: _____ Primary Care Physician: _____

Clinical Breast Concerns: _____

Current Breast Symptoms: _____

Current Treatments: _____

Current (Any) Medications: _____

Thermogram History: _____

Previous Thermogram Numbers/Grades: _____

Results of Clinical Correlation: _____

Mammogram/Ultrasound History: _____

Family History: _____

Ob/Gyn History: _____

Surgical History, Breast or Otherwise: _____

Dental History: _____

General History: _____

Current Diagnoses: _____

Skin Lesions/Physical Abnormalities: _____

Other, Non-Breast, Concerns: _____

Peak Family Chiropractic – Clinical Nutrition Program Guidelines

Welcome to Peak Family Chiropractic! We look forward to working with you! Over the years we have found that a few guidelines up front save time and avoid any misunderstandings about how our office works to serve you.

OFFICE HOURS:

Tuesdays 9:00am – 12:00pm

Additional times may be offered due to special circumstances or by appointment only.

PAYMENT

Payment for all services, product and labs is due at time of service. We accept cash, check and credit cards (VISA, MasterCard, and Discover). **NOTE**: Bounced check fee processing is $25. Payment for additional services/purchases will only be accepted in cash until the bounced check is paid in full.

Insurance: The clinical nutrition department is not a member of any insurance network and we do not process claim forms. Your insurance will not cover the cost of consultations or supplements or products purchased in the office. However, in many circumstances, your insurance may cover diagnostic or lab testing ordered by the doctor.

CANCELLATIONS AND APPOINTMENTS

When you schedule an appointment, we *reserve* that time exclusively for you. Reminder calls are a courtesy only; so please remember that you are responsible for remembering your appointment (whether a courtesy call is made or not). If you need to cancel or reschedule we do request a *minimum* of 48-hour advance notice. This is a consideration to our Health Practitioners as well as to our Clients whom would be able to utilize this time for their own health needs. Short notice, or no notice, will inflict an office visit charge equal to the cost of your originally scheduled appointment. Unavoidable emergencies will be considered reasonable exceptions. We appreciate your cooperation with this matter.

If you are late for your appointment due to traffic or other reasons, we will do our best to work you into our schedule that day, but sometimes appointments have to be rescheduled. Average office visit time is 30 minutes. If we find that we routinely need more time to properly evaluate your case, we may need to schedule two or more appointments.

RETURNS

All sales of supplements or other nutritional products are final and returns will not be accepted.

MISC

Please Read and initial the 'FEE SCHEDULE' page located on the next page of this document.

Policies and prices are subject to change at anytime.

I have read and understand the above:

Sign : _____ Date:_____

Peak Family Chiropractic Clinical Nutrition Fee Schedule

We pride ourselves on keeping costs down and we do our best to provide cost projections up front.

Clinical Nutrition Fees:

Initial Consultation/New Patient Appointment:
Generally 45-60 minutes **$180**

Lab Review, Report of Findings, Follow-Up Appointments:
Generally 20-30 minutes **$110**

Initial/Annual Breast Thermography, Including Separate Consultation to Review Findings
Breast Thermography Appointment – generally 30 minutes $**250**
Follow-up Consultation – generally 30 minutes

Follow-Up Breast Thermography, Including Separate Consultation to Review Findings
Breast Thermography Appointment – generally 30 minutes $**200**
Follow-up Consultation – generally 30 minutes

Please note the following for all appointments:

1. For follow-up appointments, if you feel you need more than 30 minutes with the Doctor, please schedule two (2) visits to ensure the full time desired is **reserved** just for you. You will be responsible for the consultation costs of both appointments.
2. Nutritional Supplements are extra and are based on your individual program. Generally, the average cost of nutritional products is $150.00 per month during the initial phases, and less for maintenance. Some cases require more, some less. Each case is different and is managed individually.
3. In most cases, laboratory and diagnostic testing recommended by the Doctor will be covered under the diagnostic benefit of most insurance companies. Coverage is different with each company and/or plan. We will do our best to advise you on co-payment responsibilities when we can. In some cases, laboratory testing will not be covered and the costs of those recommended tests will be reviewed with you prior to ordering.

I have read and understand the above: **Sign : _____Date:_____**

Peak Family Chiropractic Clinical Nutrition HIPPA Acknowledgement

I acknowledge that I have reviewed/received a copy of Peak Family Chiropractic LLC's notice of privacy practices.

☐ OK to leave detailed personal healthcare information on contact methods listed above

☐ NOT OK to leave detailed personal healthcare information on contact methods listed above

_____ _____ _____

Name of Patient (Please Print) Signature of Patient or Personal Representative Date

Authority of Personal Representative to sign for patient (circle one): Parent Guardian Power of Attorney Other:

Please note, it is your right to refuse to sign this acknowledgement of patient privacy practices.

Office Use Only: I tried to obtain written acknowledgement by the individual noted above of the receipt of our Notice of Privacy Practices, but it could not be obtained because (choose one):

_____ An emergency prevented us from obtaining acknowledgment.
_____ A communication barrier prevented us from obtaining acknowledgement.
_____ The individual was unwilling to sign.
_____ Other:_____

_____

Staff Member Signature Date

Peak Family Chiropractic
INFORMED CONSENT FOR TREATMENT

I, _____, hereby authorize the practitioners of Peak Family Chiropractic to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

- **General Evaluation Procedures:** Physical examination such as palpation, ranges of motion, measurement of blood pressure, weight and Body Mass Index.
- **Common Diagnostic Procedures:** General physical exams, radiology, laboratory, neurological and musculoskeletal assessments, x-ray and other imaging procedures if indicated.
- **Dietary Advice and Therapeutic Nutrition:** The use of foods, diet plans, or nutritional supplements for support of health.
- **Botanical Medicine:** Botanical substances may be prescribed as teas, alcohol/glycerin tinctures, capsules, tablets, powders, salves, creams, pastes, plasters, washes or suppositories.
- **Homeopathic Medicine and Tissue Salts:** The use of highly dilute quantities of naturally occurring plants, animals and minerals to gently stimulate the body's healing responses.
- **Lifestyle Counseling and Hygiene:** Promotion of wellness through exercise, sleep, stress reduction, work and life balance, and thoughts and behaviors favorable to health and well-being.
- **Flower Essences:** The use of flower remedies soaked in water and preserved with minute quantities of alcohol, which can address the psycho-emotional aspect of an individual.
- **Soft Tissue and Osseous Techniques:** The use of bodywork, traction, neuromuscular techniques, muscle manipulation, massage, craniosacral therapy, visceral manipulation, stretching and movement of spine and extremities to improve health.

Potential Risks and Benefits

Potential Risks: Allergic reactions to prescribed herbs and supplements or possible side effects which may include nausea, gas, stomachache, vomiting, headache, diarrhea, or rashes, side effects of natural medications, inconvenience of lifestyle changes, and an aggravation of pre-existing symptoms.
Potential Benefits: Restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.
Notice to Pregnant Women: All female patients must alert the doctor/practitioner if they know support that they are pregnant as some of the therapies used could present a risk to the pregnancy.

I recognize the potential risks and benefits of these procedures as described above, and I understand that I may ask questions regarding my therapy before signing this form. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Peak Family Chiropractic or any personnel regarding cure or improvement of my condition. I do not expect the practitioners at Peak Family Chiropractic to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the practitioner's judgement during the course of treatment; what the practitioner thinks at the time, based upon the facts presented, is in my best interest. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed my myself, or my representative, or unless it is required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. 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

_____
Signature of Patient Date

_____
Signature of Patient Representative or Guardian Date