**MOMENTUM CHIROPRACTIC WELLNESS SUITE - PATIENT INFORMATION**

## 1 PERSONAL INFORMATION

Date_____ Birthdate _____

Patient Name _____

*Last Name* *First Name* *MI*

Are you currently a patient at Momentum Chiropractic? Yes No

***(If YES, skip to section 3)***

Address _____

City_____ State_____ Zip_____

Sex(circle) Male Female Age_____

Height _____ Weight _____

Marital Status (circle) Married Single Divorced Widowed Other

Occupation_____ Employer_____

Spouse's Name_____ Occupation _____

How did you hear about our office? (circle) Existing Patient Employer

Internet Another Provider Insurance Co. Business Card Other

Who may we thank for referring you?_____

## 2 CONTACT INFORMATION

Email _____

Home Phone (____)_____ Cell Phone (____)_____

Work Phone (____)_____ Other _____

Best time and place to reach you_____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship_____ Phone (____)_____

## 3 FINANCIAL INFORMATION

Who is responsible for this account?_____

Relationship to Patient _____

*Please note, Nutritional Testing is a non-billable service, so patient is responsible for all charges, and payment is due at the time of service.*

# Informed Consent For Nutrition Testing

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, Herb or Homeopathic Remedy may have an effect of 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 a 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 biomechanical processes of the human body.

Nutritional advice and nutritional intake may also enhance the stabilization of chiropractic adjustments and treatment.

Patients under 18 years of age must have a parent/guardian with them during their visit.

I have read and understand the above.

_____

Patient / Parent Signature Printed Name Date

# Financial Agreement

Nutrition testing is not a billable service and therefore the patient is financially responsible for any charges they incur. Insurance does not cover nutrition testing and payment is due at the time of service for services, supplements, labs, and any other products.

Nutrition programs are purchased as a 3 month program for $300 plus the cost of supplements. Nutrition program includes: evaluation, bloodwork (offsite), complete nutritional analysis, Doctors report, & 2 onsite nutrition appointments.

By signing below I affirm that I understand the above statements and I agree to pay in full at the time of service for all charges. Payment is made at the front desk.

_____

Patient / Parent Signature Printed Name Date

**Please ask at the front desk if you would like a copy of this page for your records**

# Authorization for Use/Disclosure of Protected Health Information

We are very concerned with protecting your privacy. While the law requires that you give us this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health information.

- We may have to disclose your health information to another provider or hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.
- We may need to disclose your health information to Science Based Nutrition to obtain test results and reports.
- We may need to use your health information within our practice for quality control or other operational purposes.

I authorize Momentum Chiropractic, LLC to contact me with information related to my personal health needs and interests. The office may use any phone number or email in my personal records to contact me. I may be contacted about appointment reminders/changes, information about treatments, presentations, or events, and other health related information pertinent to me. (NOTE: No clinical or treatment information will be used or disclosed.)

Momentum Chiropractic, LLC fully supports the protection of health information. Only the chiropractor and office staff will use this information to contact you. This authorization will remain valid for ten (10) years from the date of signature and can be modified or revoked by written request.

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Patient / Parent Signature Printed Name Date