INFINITY WELLNESS CENTER
Chiropractic & Acupuncture

Nasal Specific Intake Form

Name:		**Email:**
Address:		
City, State, Zip:	**Date of Birth:**	**Age:**
Home Phone:		**Cell Phone:**
Emergency Contact (Name & Phone):		**Marital Status:**
Referred by:		**Employer:**
Occupation:		
Have you ever had Nasal Specific before?		**Chinese herbal medicine?**
Reason for today's visit:		
How long have you had this condition?		**Is it getting worse?**
Does it bother your: ☐ **Sleep**	☐ **Work**	☐ **Other (What?)**
Is this your first time with this condition?		
What seems to make it better?		**What seems to make it worse?**
Other concurrent therapies?		

Nasal Specific Technique Informed Consent

While Nasal Specific Technique has safely and quickly benefited many people suffering from a wide variety of ailments since the 1930's, the incredible technique can be quite intense and even scary until the recipient gets used to the experience.

Each of the eights balloon inflations during treatment feel as though you are clearing air through your ears while holding your nose and mouth. Some describe it as feeling like water is going up their nose but without water. During acute ear or sinus infections, the pressure can be quite intense and diminished quickly after the procedure.

Popping or "cracking" of the facial and cranial bones as well as soreness of the jaw, teeth, facial bones, and cranial sutures is normal and expected. Rarely, nasal capillaries are ruptured, and nosebleeds occur which are quickly stopped with a natural coagulant.

When cranial and facial tension is released, profound healing takes place. As with most healing, the body will often display symptoms of healing. The symptoms may include sinus pressure and drainage, gum, jaw, and facial soreness, headaches, and lightheadedness. Symptoms can range from mild to moderate depending on the degree of cranial tension released.

You can expect to notice continued improvement in wellbeing for up to 3 weeks following a nasal specific series. Healing symptoms will last anywhere from 1 to 7 days. Try and avoid over-the-counter pain relievers and sinus drugs as they may decrease overall effectiveness and burden the kidneys, digestive tract, and liver.

Take the prescribed synergistic nutrients to help maximize effectiveness and diminish uncomfortable healing symptoms. Additionally, following up nasal specific treatments with cold laser therapy will accelerate and maximize healing.

Latex allergies, severe osteoporosis and blood thinners are the only known contraindications.

I have read and understand the contraindications to Nasal Specific technique and am not taking blood thinners, allergic to latex, and do not have severe osteoporosis.

Initial: _____

All components of Nasal Specific technique have been explained to me. I have read and understand the potential symptoms of healing and give my full consent for treatment.

Print Name: _____ Date: _____

Your Signature: _____

AUTHORIZATION FOR CARE

I hereby authorize the doctor to work with my condition through the use of acupuncture, A.M.I.T., Class IV laser, chiropractic, cupping, decompression, dry needling, Graston, Nasal Specific technique and/or pulse. as he or she deems appropriate. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

Ownership of X-ray Films: it is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negative will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office.

Initial If Read Above: _____

TERMS OF ACCEPTANCE

When accepting a new client who is seeking acupuncture, A.M.I.T., Class IV laser, chiropractic, cupping, decompression, dry needling, Graston, Nasal Specific technique and/or pulse, it is essential for both the client and the doctor to be working towards the same objective. Chiropractic has only one goal to work toward the cause, not the effect. It is only when the client understands both the objective and the method that they will be able to attain it. This will prevent any confusion or disappointment.

An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine. Health is a state of optimal physical, mental, and social well-being, not merely the absence of disease. Vertebral Subluxation is a misalignment of one or more of the joints in the body. This can cause pain or alteration of nerve function and interference of the transmission or nerve impulses, lessening the body's innate ability to maintain maximal health.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not off to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I have read and fully understand the above statement. Any questions regarding the Doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Initial If Read Above: _____

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information.
I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.
- You may request a super bill, documentary of visits by email.

I have read and understood your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and /or disclosed.

PATIENT NAME (PLEASE PRINT):	**RELATIONSHIP TO PATIENT (IF MINOR):**
SIGNATURE:	**DATE:**

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Consent to Text Messaging Reminders/Missed Appointments

I give permission consent to receive text messages from Infinity Wellness Center through Ring Central:

(1) Infinity Wellness Center may send text messages in various formats, including but not limited to, text messages about appointment reminders or missed appointments.
(2) You are the owner or authorized user of the mobile phone number identified below. You will notify us immediately if you are no longer the owner or authorized user of the mobile phone number identified below.
(3) You are solely responsible for any message and data charges associated with text messaging.

If you do not wish to receive text messages from Infinity Wellness Center, please do not sign this form.

Client Name: _____

Signature: _____

Mobile Phone Number: _____

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Empowering Others

Sometimes we take photos in our office to document the progress of results and care.
Often, those photos can be used to **empower** and **educate** other families the power of chiropractic/acupuncture/dry needling/cupping/PEMF/AMIT/laser therapy/decompression/Nasal Specific for similar things going on.
You are answering below on behalf of yourself or your child for these photos to be used for printed or web materials for potential educational opportunities.

_____Initials to say **YES**

_____Initials to say **NO**