



### WELCOME TO OUR PRACTICE.

Date \_\_\_\_\_ Pt # \_\_\_\_\_

Patient \_\_\_\_\_  
First Middle Last

I prefer to be called \_\_\_\_\_

Address \_\_\_\_\_

City State Zip

Cell # \_\_\_\_\_ Cell Provider \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_

Email \_\_\_\_\_

Reminders:  Text or  Email? \_\_\_hr or \_\_\_day before?

Gender:  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Patient's SS# \_\_\_\_\_

Single  Married  Other

Right-handed  Left-handed  Ambidextrous

Preferred Language \_\_\_\_\_

The following two questions are requested as part of CMS EHR Incentive Program to identify gaps in care.

Race:  American Indian or Alaska Native,  Asian,  Black or African American,  Native Hawaiian or Other Pacific Islander,  White,  Other.

Ethnicity:  Hispanic or Latino,  Not Hispanic or Latino.

Employed  Full-time student  Part-time student

Occupation \_\_\_\_\_

Employer or School \_\_\_\_\_

Employer or School Address \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Spouse's Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Spouse's Occupation \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Spouse's Cell # \_\_\_\_\_ Work # \_\_\_\_\_

### IN CASE OF EMERGENCY, CONTACT

Spouse or  Other Contact:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Cell # \_\_\_\_\_ Work # \_\_\_\_\_

### CONSENT & POLICIES

1. I understand and agree to allow the clinic to use my Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. **The information authorized for release may include records which may indicate the presence of a communicable or noncommunicable disease.**

2. I hereby authorize the clinic, Dr. Michael K. Van Antwerp, and his assigns to examine, test, x-ray, and administer treatment to me as they deem necessary.

3. I understand that all first visit charges are payable when services are rendered. I will be taking care of today's charges by:  Cash  Check  Credit Card  Voucher  Auto insurance

4.  I choose to decline receipt of my CMS EHR Incentive Program clinical summary after every visit. (Checking this box means you do not want a list of diagnosis codes or often just a blank summary, etc after every visit. This is separate from requesting your medical records which you can do at any time).

\_\_\_\_\_  
Patient Signature (or Parent/Guardian Signature) Date

### YOUR MEDICAL DOCTOR

Doctor \_\_\_\_\_ MD/DO  
First Last

Location \_\_\_\_\_

We like to coordinate care with your medical doctor.  
May we send reports to this doctor?  Yes  No

### CONSENT TO TREATMENT OF A MINOR CHILD

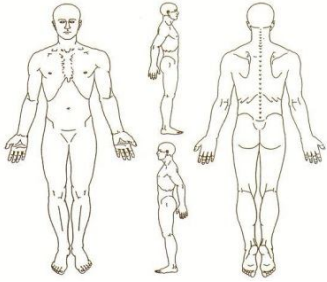
I hereby authorize the clinic including Dr. Michael K. Van Antwerp and his assigns to examine, test, x-ray, and administer treatment as they deem necessary to my child \_\_\_\_\_. This shall extend to subsequent office visits with or without my presence. This is to serve as long-term authorization and is to apply to all occasions of service until it is revoked in writing.

\_\_\_\_\_  
Parent or Guardian Signature Date

\_\_\_\_\_  
Witness Signature Date

► **CHIEF COMPLAINTS and ► HISTORY OF PRESENT ILLNESS:**

We address a wide range of complaints. Please, mark the major area(s) that you are seeking care for today:



- Headache  Jaw  Neck  Upper Back  Mid Back  Low Back  Pelvis  Hip  Thigh
- Knee  Lower Leg  Ankle  Foot  Toe B 2 3 4 5  Shoulder  Upper Arm  Elbow
- Forearm  Wrist  Hand  Finger T 2 3 4 5  Chest  Ribs  Tailbone  Groin  \_\_\_\_\_

Other problems:

- Digestion  Breathing  Sleeping  Concentration  Lack of energy  Sick a lot  Stress

Write in the top three (or less) problem areas in order of importance, indicate R (right) or L (left), and mark additional information about them. Intensity is 0=no intensity and 10=worst intensity.

<b>1.</b> _____	Intensity Right Now: 0 1 2 3 4 5 6 7 8 9 10	Intensity Typical/Avg: 0 1 2 3 4 5 6 7 8 9 10	Intensity at its Best: 0 1 2 3 4 5 6 7 8 9 10	Intensity at its Worst: 0 1 2 3 4 5 6 7 8 9 10	QVAS Score: (#1+#2+#4)(10)/3
Percentage of day occurs: <input type="checkbox"/> 75-100 <input type="checkbox"/> 50-75 <input type="checkbox"/> 25-50 <input type="checkbox"/> 0-25		Symptoms: <input type="checkbox"/> Pain <input type="checkbox"/> Stiffness <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Swelling <input type="checkbox"/> Weakness			
Radiates: <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> None		Date started: ____/____/____			
Pain is: <input type="checkbox"/> Pulling <input type="checkbox"/> Aching <input type="checkbox"/> Squeezing <input type="checkbox"/> Stabbing <input type="checkbox"/> Itching <input type="checkbox"/> Cutting <input type="checkbox"/> Burning					
How did problem occur?					
Notes:					

<b>2.</b> _____	Intensity Right Now: 0 1 2 3 4 5 6 7 8 9 10	Intensity Typical/Avg: 0 1 2 3 4 5 6 7 8 9 10	Intensity at its Best: 0 1 2 3 4 5 6 7 8 9 10	Intensity at its Worst: 0 1 2 3 4 5 6 7 8 9 10	QVAS Score: (#1+#2+#4)(10)/3
Percentage of day occurs: <input type="checkbox"/> 75-100 <input type="checkbox"/> 50-75 <input type="checkbox"/> 25-50 <input type="checkbox"/> 0-25		Symptoms: <input type="checkbox"/> Pain <input type="checkbox"/> Stiffness <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Swelling <input type="checkbox"/> Weakness			
Radiates: <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> None		Date started: ____/____/____			
Pain is: <input type="checkbox"/> Pulling <input type="checkbox"/> Aching <input type="checkbox"/> Squeezing <input type="checkbox"/> Stabbing <input type="checkbox"/> Itching <input type="checkbox"/> Cutting <input type="checkbox"/> Burning					
How did problem occur?					
Notes:					

<b>3.</b> _____	Intensity Right Now: 0 1 2 3 4 5 6 7 8 9 10	Intensity Typical/Avg: 0 1 2 3 4 5 6 7 8 9 10	Intensity at its Best: 0 1 2 3 4 5 6 7 8 9 10	Intensity at its Worst: 0 1 2 3 4 5 6 7 8 9 10	QVAS Score: (#1+#2+#4)(10)/3
Percentage of day occurs: <input type="checkbox"/> 75-100 <input type="checkbox"/> 50-75 <input type="checkbox"/> 25-50 <input type="checkbox"/> 0-25		Symptoms: <input type="checkbox"/> Pain <input type="checkbox"/> Stiffness <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Swelling <input type="checkbox"/> Weakness			
Radiates: <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> None		Date started: ____/____/____			
Pain is: <input type="checkbox"/> Pulling <input type="checkbox"/> Aching <input type="checkbox"/> Squeezing <input type="checkbox"/> Stabbing <input type="checkbox"/> Itching <input type="checkbox"/> Cutting <input type="checkbox"/> Burning					
How did problem occur?					
Notes:					

- How much have your symptoms interfered with your usual daily activities?  
 Not at all  A little bit  Moderately  Quite a bit  Extremely
- How is your condition changing since beginning care at this facility?  **N/A - This is the initial visit**  
 Much better  Better  A little better  No change  A little worse  Worse  Much worse
- In general, would you say your overall health right now is  Excellent  Very good  Good  Fair  Poor
- Previous chiropractic care?  No  Yes    Were extremities, muscles, and exercises addressed?  No  Yes  
What did you like? \_\_\_\_\_ What did you not like? \_\_\_\_\_

The information on this page is accurate to the best of my knowledge. **Patient Signature: X** \_\_\_\_\_

Pt Name \_\_\_\_\_ Pt # \_\_\_\_\_ Date \_\_\_\_\_ Reviewed \_\_\_\_\_

► **REVIEW OF SYSTEMS:** Mark any of the following you have for each category or mark "N" for none in that section.

- |  |   |   |  |
|--|---|---|--|
| <u>Constitutional:</u> <input type="checkbox"/> N  | <u>Cardiovascular:</u> <input type="checkbox"/> N   | <input type="checkbox"/> Urinary tract infections | <u>Psychiatric:</u> <input type="checkbox"/> N           |
| <input type="checkbox"/> Unexpected weight loss    | <input type="checkbox"/> Chest pains                | <input type="checkbox"/> Menstrual irregularity   | <input type="checkbox"/> Depression                      |
| <input type="checkbox"/> Fever                     | <input type="checkbox"/> Palpitations               | <input type="checkbox"/> Menstrual cramps         | <input type="checkbox"/> Anxiety                         |
| <input type="checkbox"/> Chills                    | <input type="checkbox"/> Edema                      | <input type="checkbox"/> Loss of bladder control  | <input type="checkbox"/> Sleep disorder                  |
| <input type="checkbox"/> Night sweats              | <input type="checkbox"/> Cold extremities           | <u>Musculoskeletal:</u>                           | <input type="checkbox"/> Forgetfulness                   |
| <input type="checkbox"/> Fatigue                   | <input type="checkbox"/> Fainting or near-fainting  | *See chief complaints                             | <input type="checkbox"/> Confusion                       |
| <input type="checkbox"/> Loss of appetite          | <u>Gastrointestinal:</u> <input type="checkbox"/> N | <input type="checkbox"/> Joint degeneration       | <input type="checkbox"/> Drug problem                    |
| <input type="checkbox"/> Loss of sleep             | <input type="checkbox"/> Nausea                     | <input type="checkbox"/> Difficulty walking       | <input type="checkbox"/> Alcohol problem                 |
| <input type="checkbox"/> Night pain that wakes you | <input type="checkbox"/> Vomiting                   | <input type="checkbox"/> Weakness                 | <u>Endocrine:</u> <input type="checkbox"/> N             |
| <u>Eyes:</u> <input type="checkbox"/> N            | <input type="checkbox"/> Diarrhea                   | <u>Integumentary:</u> <input type="checkbox"/> N  | <input type="checkbox"/> Frequent thirst                 |
| <input type="checkbox"/> Blurry/Double vision      | <input type="checkbox"/> Constipation               | <input type="checkbox"/> Bruises/scrapes/cuts     | <input type="checkbox"/> Frequent urination              |
| <input type="checkbox"/> Corrective lenses         | <input type="checkbox"/> Heartburn/indigestion      | <input type="checkbox"/> Rash                     | <input type="checkbox"/> Heat/cold intolerance           |
| <input type="checkbox"/> Vision loss               | <input type="checkbox"/> Gas                        | <input type="checkbox"/> Sores                    | <input type="checkbox"/> Goiter                          |
| <u>Ear/Nose/Throat:</u> <input type="checkbox"/> N | <input type="checkbox"/> Bloating                   | <input type="checkbox"/> Clammy, moist skin       | <u>Hematologic/Lymphatic:</u> <input type="checkbox"/> N |
| <input type="checkbox"/> Hearing loss              | <input type="checkbox"/> Ulcers                     | <input type="checkbox"/> Nail/hair changes        | <input type="checkbox"/> Easy bruising/bleeding          |
| <input type="checkbox"/> Ringing in ears           | <input type="checkbox"/> Blood in stool             | <input type="checkbox"/> Breast pain/lumps        | <input type="checkbox"/> Blood clots                     |
| <input type="checkbox"/> Sinus problems            | <input type="checkbox"/> Abdominal pain             | <u>Neurological:</u> <input type="checkbox"/> N   | <input type="checkbox"/> Swollen lymph nodes             |
| <input type="checkbox"/> Tooth cavities            | <input type="checkbox"/> Loss of bowel control      | <input type="checkbox"/> Numbness                 | <u>Allergic/Immunologic:</u> <input type="checkbox"/> N  |
| <input type="checkbox"/> Hoarseness                | <u>Genitourinary:</u> <input type="checkbox"/> N    | <input type="checkbox"/> Tingling                 | *See allergies list                                      |
| <input type="checkbox"/> Trouble swallowing        | <input type="checkbox"/> Painful urination          | <input type="checkbox"/> Groin/crotch numbness    | <input type="checkbox"/> Hives                           |
| <u>Respiratory:</u> <input type="checkbox"/> N     | <input type="checkbox"/> Blood in urine             | <input type="checkbox"/> Migraines                | <input type="checkbox"/> Anaphylactic reactions          |
| <input type="checkbox"/> Chronic cough             | <input type="checkbox"/> Kidney problems            | <input type="checkbox"/> Dizziness                | <input type="checkbox"/> Sick frequently                 |
| <input type="checkbox"/> Shortness of breath       | <input type="checkbox"/> Prostate problems          | <input type="checkbox"/> Seizures                 |  |
| <input type="checkbox"/> Wheezing                  | <input type="checkbox"/> Sexual dysfunction         | <input type="checkbox"/> Tremors                  |  |

<p>FEMALES Date of Last Period _____ <b>Are you pregnant?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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► **MEDICAL HISTORY**

CONDITIONS: Mark any of the following you have had or if do not have any of the conditions listed below mark  None.

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Aneurysm               | <input type="checkbox"/> Ehlers-Danlos syn.____   | <input type="checkbox"/> Immunosuppressive meds   | <input type="checkbox"/> Pacemaker               |
| <input type="checkbox"/> Ankylosing spondylitis | <input type="checkbox"/> Epilepsy                 | <input type="checkbox"/> Injection drug use       | <input type="checkbox"/> Psoriasis               |
| <input type="checkbox"/> Anticoagulant meds     | <input type="checkbox"/> Gout                     | <input type="checkbox"/> Joint laxity/instability | <input type="checkbox"/> Recent infection        |
| <input type="checkbox"/> Asthma/COPD            | <input type="checkbox"/> Heart attack, year _____ | <input type="checkbox"/> Kidney failure           | <input type="checkbox"/> Rheumatoid arthritis    |
| <input type="checkbox"/> Bone/Joint infection   | <input type="checkbox"/> Heart failure            | <input type="checkbox"/> Liver disease            | <input type="checkbox"/> Sjogren syndrome        |
| <input type="checkbox"/> Cancer, type _____     | <input type="checkbox"/> Hemophilia               | <input type="checkbox"/> Low/High thyroid         | <input type="checkbox"/> Sleep apnea             |
| <input type="checkbox"/> Chiari, type _____     | <input type="checkbox"/> Hepatitis, type _____    | <input type="checkbox"/> Marfan syndrome          | <input type="checkbox"/> Stroke                  |
| <input type="checkbox"/> Corticosteroid meds    | <input type="checkbox"/> High/Low blood pressure  | <input type="checkbox"/> Multiple sclerosis       | <input type="checkbox"/> Tuberculosis            |
| <input type="checkbox"/> Diabetes, type _____   | <input type="checkbox"/> HIV/AIDS                 | <input type="checkbox"/> Osteoporosis             | <input type="checkbox"/> Vertebrobasilar insuff. |

Do you have ALLERGIES to any medications/drugs?  Yes  No. If yes, then list:

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Mark any other known allergies:  Adhesive tape  Latex  Iodine  Contrast dye  Seasonal  Food  Animal \_\_\_\_\_

Do you take MEDICATIONS?  Yes  No. Any SUPPLEMENTS?  Yes  No. If yes to either, list with dosage amount:


List any INJURIES/OPERATIONS you have had with a description and the year, or if haven't had any mark  None.

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Auto Accidents _____ | <input type="checkbox"/> Broken Bones _____          | <input type="checkbox"/> Sprains/Strains _____ |
| <input type="checkbox"/> Falls _____          | <input type="checkbox"/> Dislocations _____          | <input type="checkbox"/> Surgeries _____       |
| <input type="checkbox"/> Head Injuries _____  | <input type="checkbox"/> Implants/Replacements _____ |  |

► **FAMILY HISTORY:** Mark if any direct relatives have had the following, or if they haven't mark  None.  Same condition as you \_\_\_\_\_  High blood pressure \_\_\_\_\_  Diabetes \_\_\_\_\_  Rheumatoid arthritis \_\_\_\_\_  Premature death \_\_\_\_\_

► **SOCIAL HISTORY**

- Do you smoke or chew tobacco?  Daily  Occasionally  Previously  Never. If so, how much? \_\_\_\_\_
- Alcohol use?  None  Social  Daily  Frequently • Past or present drug abuse?  Yes  No
- Work Habits:  Sitting  Standing  Driving  Bending  Lifting
- Exercise:  \_\_\_ days/week  Occasionally  None. • What activities or hobbies? \_\_\_\_\_

The information on this page is accurate to the best of my knowledge. **Patient Signature: X** \_\_\_\_\_

Pt Name \_\_\_\_\_ Pt # \_\_\_\_\_ Date \_\_\_\_\_ Reviewed \_\_\_\_\_

PATIENT MOTOR VEHICLE COLLISION HISTORY FORM

Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Loss (Collision Date): \_\_\_\_\_ Claim Number: \_\_\_\_\_

Describe Accident:

\_\_\_\_\_  
\_\_\_\_\_

Specifics of Accident (Mark each that applies to the accident):

Job or Work Related injury  Yes  No

You were the  Driver  Passenger  
Sitting  Front seat  Back seat

Impending collision  Braced  Not braced  
Head did  Strike Object  Not strike Object  
Did you experience  Shock  
 Flash of light seen upon impact  
 Objects flying around vehicle

Immediately Following the Accident:

- Police came to scene and made report
- Ambulance/paramedics called
- Treated at scene
- Transported to hospital by ambulance
- Went to hospital or urgent care on your own
- Diagnostics performed at hospital or urgent care
- Medication prescribed
- Treatment at hospital or urgent care
- Follow-up recommended by healthcare providers

Time Loss

- NO time loss from work due to injury. I am currently working with No limitations.
- NO time loss form work due to injury BUT I do have limitations\*.
- I have experienced time loss from work due to injury. Indicate number of days, weeks, etc
- N/A

\*Describe limitations and what activities have been negatively affected:

\_\_\_\_\_  
\_\_\_\_\_

Mechanism of Injury

- Were you surprised by the impact?  Yes  No
- In relation to the back of your head, was your headrest set:  Low  Middle  High  None
- Where was your head facing at the time of impact?  Left  Forward  Right  Unknown
- Were you leaning forward at the time of impact?  Yes  No
- Were you wearing a seatbelt?  Yes  No
- Did you have bruises or cuts from the seatbelt?  Yes  No
- Did airbags deploy?  Yes  No
- Did you have burns, scrapes, cuts or bruises from the airbag?  Yes  No
- Were you rendered unconscious as a result of the accident?  Yes  No
- Did you feel pain immediately after the accident?  Yes  No

Year and type of vehicle were you in? \_\_\_\_\_

Size of your vehicle?  Small  Mid  Large  Unknown

Year and type of other vehicle involved in the accident? \_\_\_\_\_

Size of other vehicle?  Small  Mid  Large  Unknown

What was the approximate speed of your vehicle when the accident occurred? \_\_\_\_\_

What was the approximate speed of the other vehicle when the accident occurred? \_\_\_\_\_

The information on this page is accurate to the best of my knowledge. Patient Signature: X \_\_\_\_\_

Pt Name \_\_\_\_\_ Pt # \_\_\_\_\_ Date \_\_\_\_\_ Reviewed \_\_\_\_\_

## INFORMED CONSENT

Dear Patient:

Healthcare providers need to obtain your informed consent prior to examination and treatment. The purpose of this form is to inform you, not to alarm you. What you are being asked to sign is simply a confirmation that we have discussed the following:

### ASSOCIATES AND ASSISTANTS

In this office we use trained staff personnel to assist Dr. Michael K. Van Antwerp (hereinafter, "doctor") with portions of your consultation, examination, and treatment. Occasionally when the doctor is unavailable another clinic doctor might treat you.

### EXAMINATIONS

Physical Examination: Certain orthopedic, neurological, and chiropractic tests are designed to aggravate a condition in order to identify it properly. These tests have the possibility of making your condition more painful, sore, or worse, at least temporarily. These problems occur so rarely we have not been able to find available statistics to quantify their probability.

X-ray: Concerning x-ray examination, this office uses highly sensitive screens that provide the highest quality with the least exposure. This is important since certain conditions will call for the retaking of certain x-rays when circumstances warrant.

The noteworthy inherent risk with taking x-rays deals with pregnancy. If there is a possibility that you are pregnant, inform this office prior to x-ray examination. If there is no possibility of this condition, the inherent risks are so rare that we have no available statistics to quantify their probability.

### TREATMENT

Manipulative Therapy/Adjusting: The doctor will use his hands or a mechanical device upon your body in such a way as to move your joints. This procedure may cause an audible "pop" or "click" much as you have experienced when you "crack" your knuckles.

Acupuncture: The doctor and/or his assigns will use an electrostimulation device, low level laser, scraping tool, percussion tool, finger pressure, or very fine needles to stimulate certain acupuncture points.

There are some material risks involved in doing these, and they are as follows:

### INHERENT RISKS

Pain: It is common for an adjustment as well as traction, massage therapy, exercises, acupuncture, in fact almost any treatment, to result in a temporary increase in soreness in the region being treated.

Soft Tissue Injury: Soft tissue, such as ligaments and muscles may be stretched or torn during an adjustment. The result is a temporary increase in pain. However, there are no long term effects. These problems occur so rarely we have not been able to find available statistics to quantify their probability.

Rib Fractures: The force of an adjustment might "crack" a rib. This can happen with anyone; however, it occurs most often on patients that have weakened bones from such things as osteoporosis. Osteoporosis that is severe enough can be noted on your x-rays and when detected, we proceed with extra caution. These problems occur so rarely that we have not been able to find any available statistics to quantify their probability.

Disc Herniations: Occasionally treatment will aggravate or cause a problem if the disc is in a weakened state. It is possible that surgery may become necessary for correction, but again these problems occur so rarely that we have not been able to find available statistics to quantify their probability.

Stroke: Even though strokes happen with some frequency in our world, strokes resulting from a chiropractic adjustment are rare. This is so rare that you have the same chance of getting hit by lightning, which is around one in a million. However, this office feels that these great odds can be further reduced by tests performed in this office. Prior to treatment you will be given such tests to further reduce your risk.

Physical Therapy Burns: Some of the machines we use generate heat. We also use ice in the office. Since everyone's skin has different sensitivity to these modalities, we test our patients for sensitivity deficiencies prior to therapy use. If a burn is obtained,

there will be a temporary pain and possible blistering. This should be reported to the doctor. This is so rare that we have not found any statistics to quantify their probability.

Infection: Needle acupuncture has the potential to cause infection. However, we adhere to clean needle technique including sealed sterile disposable needles which greatly reduce the risk of infection. The literature is still unclear about risk, but it has been estimated at the low rate of less than 1 in 10,000.

Puncture: Needle acupuncture has the potential to cause mechanical injury to the lungs, heart, blood vessels, muscles, spine, and/or nerves. Penetration has to be fairly deep to cause damage which is why we use shallow needle technique and avoid contraindicated areas. Risk statistics are still unclear, but it has been estimated at the low rate of less than 1 in 10,000.

Other Problems: There may be other problems or complications that might arise from treatment, such as massage, traction, etc., other than noted above. Temporary nausea, dizziness, fainting, pain, and bruising might occur from chiropractic treatment. Temporary nausea, dizziness, fainting, pain, bruising, and local bleeding might occur from acupuncture treatment. These other problems or complications occur so rarely that it is not plausible to anticipate and/or explain them all in advance of treatment.

#### OTHER AVAILABLE TREATMENT

Medication: Medication may be used to relieve pain and swelling. However, medication can mask progress and the efficiency of chiropractic treatment. Caution should be used since the danger of side effects and damage to the health of a person taking the medication is well documented.

Hospitalization: Hospitalization has proven expensive and dangerous. The documentation of such is overwhelming.

Surgery: Surgery is always a possibility. The expense, danger, and ineffectiveness of such treatment is more a probability than a possibility.

#### NON TREATMENT

Remaining untreated, results in adhesions, pain, and reduction in associated joint mobility. The probability that these adhesions will interfere with the motion, function, and enjoyment of life is very high.

#### PATIENT HEALTH INFORMATION ("PHI")

Our office uses open adjusting and treatment rooms. The possibility that one's adjustment, treatment, and/or name may incidentally be observed and the possibility that conversations and/or names may incidentally be overheard are terms and conditions that the patient agrees to in this office. We try to limit incidental disclosures as much as possible and adhere to minimum necessary and reasonable safeguard requirements as required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). If private room adjusting is requested, arrangements will be made. We do respect your privacy, so a private room is available for conversations if needed. Your chart notes might be handed to you to fill out. It is your responsibility to guard these as you see fit while they are in your possession.

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I UNDERSTAND THE UNDESIRE RESULTS OF EXAMINATION AND TREATMENT AND HAVE GONE OVER ANY QUESTIONS I MIGHT HAVE.

I hereby authorize and direct the above named physician and assigns to provide such additional services as they may deem reasonable and necessary.

I HEREBY STATE THAT I HAVE READ OR HAVE HAD READ TO ME THIS CONSENT FORM.

A photocopy of this Informed Consent shall be considered as effective and valid as the original.

\_\_\_\_\_  
Patient Printed Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian Printed Name

\_\_\_\_\_  
Parent or Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Printed Name

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

## RELEASE AND ASSIGNMENT

*The following agreements are necessary because insurance is an arrangement between you and the insurance company. The doctor and the clinic are not part of this arrangement, and thus need your release, assignment, and authorization.*

1. I \_\_\_\_\_ authorize the request, release, and disclosure of any medical, health care, or other information necessary to process my insurance claims, to secure the payment of benefits, and to manage my care including communication with insurance companies, claims adjusters, case nurses, claims reviewers, employers, hospitals, clinics, healthcare providers, and attorneys. I understand that this might include multiple occurrences. This is to serve as a long-term authorization card. **The information authorized for release may include records which may indicate the presence of a communicable or noncommunicable disease.** This language is included as required by 63 O.S. § 1-502.2.

2. I directly assign my rights and benefits under my policy and authorize payment of all benefits directly to Dr. Michael K. Van Antwerp (hereinafter, "doctor") and ZOVA (hereinafter, "clinic"). This payment will not exceed my indebtedness to the above-mentioned doctor and clinic, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. I understand that I am ultimately responsible for the charges. This authorization is to apply to all occasions of service until it is revoked in writing.

3. If my current policy prohibits direct payment to doctor and clinic then I hereby instruct and direct the insurance company to make check to me as a patient and to mail it to me as follows: ZOVA, 2433 N. Aspen Ave., Broken Arrow, OK 74012

4. I do hereby designate Dr. Michael K. Van Antwerp and ZOVA to the full extent permissible under the Employee Retirement Income Security Act of 1974 ("ERISA") and as provided in 29 CFR 2560-503-1(b)4 to otherwise act on my behalf as my agent to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or other health care expense(s) incurred as a result of the goods and/or services I receive from the above-named doctor and clinic. These rights include the right to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records, and to claim on my behalf such medical or other health care service benefits, insurance or health care benefit plan reimbursement and to pursue any other applicable remedies, all in connection with medical or other health care expense(s) as the result of the goods and/or services I received from my doctor and clinic.

5. I agree that a photocopy of this agreement shall be effective and valid as the original.

\_\_\_\_\_  
Patient Printed Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian Printed Name

\_\_\_\_\_  
Parent or Guardian Signature

\_\_\_\_\_  
Date

## CANCELLATION POLICY

*Due to the nature of our clinic's one-on-one treatment, any last-minute cancellations or missed appointments can prevent another patient from getting much needed treatment. We understand that certain emergencies do come up, but in order to be respectful of the health needs of other patients, we need enough notice to fill your appointment with another patient. We also understand that in a healthcare clinic sometimes the schedule runs behind although we try to prevent it. To help this, any late arrivals will be seen if the provider does not have another patient waiting, otherwise the patient might have shortened treatment time or have to be completely rescheduled. To better utilize available appointments for all patients in need of care, we have the following policy:*

If an appointment is cancelled or rescheduled within 24 hours of the appointment time, the fee is 50% of the scheduled treatment. If the appointment is completely missed (no-show), the fee is 100% of the scheduled treatment. Cancellations and rescheduled appointments need to be made directly to a staff member, not via texts, emails, or voicemail. As a benefit, we do send appointment reminders via text or email, but failure to receive one is not a reason for missed appointments. Insurance and other third party forms of payment do not pay for cancelled, rescheduled or missed fees. We do require a credit card on file in case these situations occur. Thank you for your commitment to our reserved time together.

\_\_\_\_\_  
Patient Printed Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian Printed Name

\_\_\_\_\_  
Parent or Guardian Signature

\_\_\_\_\_  
Date