AS USED IN THESE DOCUMENTS, THE TERMS "WE," "OUR" AND/OR "US" REFERS TO THE LEGAL OWNER AND OPERATOR OF THIS THE THESE TERMS OF ACCEPTANCE AND ALL DOCUMENTS BELOW ARE INCORPORATED INTO YOUR APPLICABLE PLAN AGREEMENT.

EXPLANATION OF SERVICES

Routine activities regularly cause muscle spasm, joint dysfunction and fixations subluxations of the spine. These joint dysfunctions or fixations, create interference with the transmission of proper neuro-electrical conmunication through the spine and extremities. This can cause decreased joint motion, pain, discomfort and/or a lessening of the body's ability to function properly. Chiropractic focuses on conditions stemming from restricted joint motion, mainly of the spine and related nervous system, and the effects of these disorders on general health.

Our primary focus is providing patients with a pathway towards better health through ongoing chiropractic treatment consisting of maintenance and preventative care. Our number one concern is the health and safety of the people we serve. Therefore, we only accept those patients determined to have the potential to benefit from our care. To receive the most from the services provided, it is important to better understand what we do and don't do:

WHAT WE DO:

- We provide physical therapy and convenient chiropractic care often resulting in better function, improved joint motion, and a healthier, more active lifestyle.
- We accomplish our goal through the gentle application of a targeted movement where and when indicated by licensed Doctors of Chiropractic and tor physical therapist to improve motion of the body's spinal column and extremities and/or proper nerve function. This is commonly referred to as an adjustment or manual manipulation.

WHAT WE DON'T DO/ LIMITATION OF SERVICES

- We do not offer to treat any disease or condition other than muscle and joint dysfunctions associated with the spine and extremities.
- We do not accept or bill insurance, Medicare, and/or any third-party carrier for payment.
- We do not have extensive diagnostic equipment or provide invasive testing/treatment.
- Our services are limited to the reparative/preventative effects of routine care by improving joint mobility and function in the spine and extremities, and/or optimizing proper nerve function.
- Should any of our patients need additional diagnostic testing, or other forms of health care services, they will be referred to an appropriate provider or facility, when indicated.

FINANCIAL RESPONSIBILITY

30 minute treatments are $150 and 60 minute treatments are $300. All services are billed in 15 minute increments to the nearest 1/4 hour.

All patients acknowledge that they are financially responsible to remit payment in full for all services provided to them. All patients further understand and agree that we will not submit any billing data or related claim(s) for, or on, their behalf to any private insurance program, Medicare or any Secondary Medicare Insurance Program carrier with whom they have insurance coverage, unless otherwise required by applicable law.

I, _____ , have read and fully understand the above statements.

(Patient Printed Name)

All questions regarding the doctor's objectives pertaining to my care have been answered to my complete satisfaction. I therefore accept all chiropractic care provided to me at this location based upon these guidelines.

_____ _____

(Patient Printed Name) (Date)

CONSENT TO EVALUATE AND TREAT A MINOR CHILD

I, _____ of _____

(Patient Printed Name) (Child/(ren) Name)

have read and fully understand the terms of acceptance and hereby grant permission for my child(ren) to receive chiropractic care.

_____ _____

(Patient or Legal Guardian Signature) (Date)

PATIENT INFORMATION

CHIROFIT ADVANCED RECOVERY

Patient ID: _____

First Name: _____ Last Name: _____

Sex: ☐ M ☐ F Date of Birth: _____ Age: _____

1st Phone: _____ ☐ W ☐ H ☐ C 2nd Phone: _____ ☐ W ☐ H ☐ C

E-mail: _____

What is your preferred method of communication? ☐ Phone ☐ Text ☐ Email

Home Address: _____

City: _____ State: _____ ZIP Code: _____

Employer: _____

Work Address: _____

City: _____ State: _____ ZIP Code: _____

Emergency Contact: _____ Phone: _____ ☐ W ☐ H ☐ C

Are you Medicare Eligible? ☐ Yes ☐ No

Do you have a Health Savings Account (HSA) or Flexible Spending Account (FSA)? ☐ Yes ☐ No

How did you first hear about us?

_____

If you were referred by someone please tell us who so we may thank them. Referral: _____

I CONSENT to receive telephonic sales and/or marketing calls, text messages, artificial or prerecorded voice messages, and voicemail transmissions ("Calls and Texts") to the first telephone number provided above, including using an automatic telephone dialing system or an automated system for the selection or dialing of telephone numbers or the playing of a recorded message, by or on behalf of our franchisees, affiliates, vendors, and agents regarding its products and services. I authorize these telemarketing Calls and Texts even if I have previously included my telephone number(s) on any Do-Not-Call registry or list. I understand I am not required to provide this consent as a condition of purchasing any products or services. I have the authority to provide this consent. Message and data rates may apply.

_____ _____

(Patient or Legal Guardian Signature) (Date)

Name: _____ Age: _____ Date of Birth: _____ Gender: ☐ M ☐ F

Height: ____ ft. ___ in. Weight: ____ ft. ___ in. Occupation: _____ For how long? ___ yrs. ___ mos.

1. Have you had chiropractic care before? ☐ Yes ☐ No If yes, how recently? _____

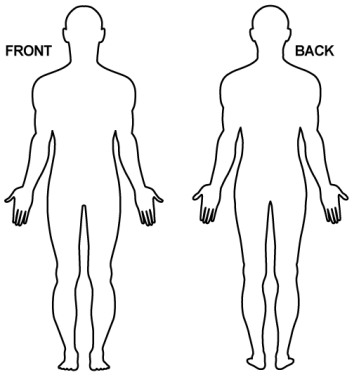
2. Reason for today's visit: ☐ Pain ☐ Discomfort ☐ Stiffness ☐ Maintenance Care ☐ Recent Injury ☐ Previous Injury ☐ Other _____

3a. When did your complaint(s) first begin? _____ 3b. Today, is the condition: ☐ Same ☐ Better ☐ Worse

Explain what helps and/or worsens the condition: _____

	4. Where is/are your area(s) of complaint today? Check all that apply	Rate pain and discomfort between 1-10 1 = minimal 10 = severe	Check the Type of Complaint							Frequency	
			Radiating	Sharp	Dull	Tingling	Numbness	Burning	Inflamed / swollen	Constant	Intermittent
☐	Headache/Migraine										
☐	Neck										
☐	Shoulder(s)										
☐	Arm(s)										
☐	Elbow(s)										
☐	Wrist(s)										
☐	Upper Back										
☐	Middle Back										
☐	Lower Back										
☐	Hip(s)										
☐	Sciatica										
☐	Knee(s)										
☐	Ankle(s)										
☐											

5. Use the figures below to place an "X" on any specific area(s) where you are experiencing pain, discomfort or limited range of motion.



6. Have you experienced this/these complaint(s) before? ☐ Yes ☐ No

For Clinic Use Only: BP: _____/_____

If yes, when? _____

7. Are you pregnant? ☐ Yes ☐ No ☐ N/A If yes, how many weeks? _____

8. Are you currently experiencing any of the following (If yes to any, please describe below): ☐ N/A

☐ Nausea or vomiting
☐ Rapid eye movement
☐ Numbness on one side of the face or body
☐ Fainting or lightheadedness
☐ Dizziness
☐ Difficulty walking
☐ Difficulty speaking
☐ Headache or neck pain
☐ Difficulty swallowing
☐ Double vision

_____

9. Current prescriptions or over-the-counter medications: _____

_____

PAST HISTORY: MUSCULOSKELETAL CONDITIONS (please check all that apply): ☐ N/A

☐ Headaches/Migraines
☐ Neck Pain/Discomfort
☐ Shoulder Pain/Discomfort
☐ Upper Back Pain/Discomfort
☐ Middle Back Pain/Discomfort
☐ Low Back Pain/Discomfort
☐ Hip Pain/Discomfort
☐ Sciatica
☐ Elbow Pain/Discomfort
☐ Wrist Pain/Discomfort
☐ Knee Pain/Discomfort
☐ Ankle Pain/Discomfort
☐ Arthritis
☐ Fused/Fixated Joints
☐ Herniated Disc
☐ Joint Replacement
☐ Osteoporosis
☐ Osteopenia
☐ Inflammation/Swelling;where: _____

OTHER CONDITIONS: ☐ N/A

☐ Cancer
☐ Tumors
☐ Stroke
☐ Seizure Disorders
☐ High Blood Pressure
☐ Pacemaker
☐ Allergies
☐ Heart Disease
☐ AIDS/HIV
☐ Diabetes
☐ Hepatitis
☐ Tuberculosis
☐ Hernia
☐ Other: _____

10. Indicate if you have experienced any of the following and mark how recently

Surgeries? ☐ Yes ☐ No ☐ Less than 1 month ☐ 1-6 months ☐ 6-12 months ☐ More than 12 months _____ yrs.

No Accidents/ Broken Bones? ☐ Yes ☐ No ☐ Less than 1 month ☐ 1-6 months ☐ 6-12 months ☐ More than 12 months _____ yrs.

Hospitalizations? ☐ Yes ☐ No ☐ Less than 1 month ☐ 1-6 months ☐ 6-12 months ☐ More than 12 months _____ yrs.

If yes to any, list and describe: _____

11. Family Health History: (check all that apply)

☐ Cancer ☐ Tumors ☐ Stroke ☐ Seizures ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ N/A

_____ _____

(Patient or Legal Guardian Signature) (Date)

INFORMED CONSENT TO CHIROPRACTIC CARE

We provide adjustments or manual manipulations through the gentle application of a targeted movement where and when indicated by a licensed Doctor of Chiropractic to improve motion of the body's spinal column and extremities.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be an effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Routine chiropractic treatment can result in better function, improved joint motion, and a healthier, more active lifestyle.

However, there are some risks associated with chiropractic adjustments, including, but not limited to the possibility of sprains, dislocations and fractures. In addition:

i. While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques:
ii. There are reported cases of stroke associated with neck movements including adjustments of the upper cervical spine. Current medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because a stroke may cause serious neurological impairment and result in injuries including paralysis.
iii. There are reported cases of disc injuries following cervical and lumbar spinal adjustments or chiropractic treatment.

The risk of injuries or complications from chiropractic treatments are substantially lower than that associated with many medical or other treatments, medications, and surgical procedures given for the same treatments.

Common alternatives to adjustments and manipulations include medications, physical therapy, other medical treatments and surgery provided by physicians and surgeons.

By signing this Informed Consent, I acknowledge that I have discussed, have had the opportunity to discuss, and/or will seek to discuss, with my Doctor of Chiropractic the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustments), the benefits, risks and alternatives to chiropractic treatment. I acknowledge that I have read and understand the contents of this Intake Form and Informed Consent and related therapy procedure forms.

I consent to the chiropractic treatments offered or recommended to me by my Doctor of Chiropractic, including spinal adjustments. I intend this consent to apply to all my present and future chiropractic care received from this clinic.

Dated this _____ day of _____ 20 _____

I understand and am informed that some risks are associated with chiropractic adjustments, including, but not limited to, sprains, dislocations, fractures, disc injuries, strokes and paralysis*

*In applicable states, please initial after reading the statement, above. Patient initials _____ Doctor initials _____

_____

(Patient Printed Name)

_____ _____

(Patient or Legal Guardian Signature) (Date)

_____ _____

(Witness / Employee Signature) (Date)

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY US, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice of Privacy Practices, please contact your local facility.

Who Will Follow This Notice of Privacy Practices?

1. Our office
2. Doctors of Chiropractic and physical therapists who provide services to you
3. All employees and subcontractors

We understand that medical information about you and your health is personal and we are committed to protecting this information. When you receive chiropractic treatment from us, a record of the treatment you receive is made. Typically, this record contains your treatment plan, your history and physical, any x-ray and test results that you provide to us, and billing record. This record serves as a:

1. Basis for planning your treatment;
2. Means of communication for or between clinic doctors and staff, the doctors and staff of other clinics operating under name, and your other health care providers, if any, that you wish us to share them with; and a
3. Tool for assessing and continually working to improve the care rendered.

This Notice tells you the ways we may use and disclose your Protected Health Information (referred to herein as "medical information"). It also describes your rights and our obligations regarding the use and disclosure of medical information.

OUR RESPONSIBILITIES

We are required by law to:

1. Maintain the privacy and security of your medical information;
2. Provide you with notice of our legal duties and privacy practices with respect to information we collect and maintain about you;
3. Abide by the terms of this notice; and
4. Notify you if we are unable to agree to a requested restriction.

The Methods in Which We May Use and Disclose Medical Information about You

The following categories describe different ways we may use and disclose your medical information. The examples provided serve only as guidance and do not include every possible use or disclosure.

1. For Treatment. We will use and disclose your medical information to provide, coordinate, or manage your chiropractic treatment at this clinic or any other clinic where you seek treatment. For example, we may share your information with your primary care physician or other specialists upon request.
2. For Payment. We will use and disclose medical information about you so that payment for the treatment you receive may be collected from you or another party.
3. For Health Care Operations. We may use and disclose medical information about you for our office operations. These uses and disclosures are necessary to run the clinic in an efficient manner and provide that all patients receive quality care. For example, your medical records may be used in the evaluation of services, and the appropriateness and quality of chiropractic treatment we provide. Chiropractic services will be provided in an open room where other patients are also receiving care. Other persons in the office may overhear some of your protected medical information during the course of care. Should you need to speak with the doctor at any time in private, a place for these conversations will be provided upon request. To the extent permitted by law, we may use cameras or other recording devices in our clinics. Any clinics having cameras or recording devises will have provide notice of the use of such devices in accordance with state and federal laws and regulations.
4. For Contacting You. We may use your address, phone number, e-mail and clinical records to contact you with notifications, text messages, birthday and holiday related messages, billing inquiries, information about treatment alternatives, or other health related information. If contacting you by phone, we may leave a message on your answering machine or voicemail.

5. Appointment Reminders. We may use and disclose medical information to remind you of an appointment, if applicable.
6. As Required by Law. We will disclose medical information about you when required to do so by federal or state laws or regulations.
7. Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. Health oversight agencies include public and private agencies authorized by law to oversee the health care system. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, eligibility or compliance, and to enforce health-related civil rights and criminal laws.
8. Lawsuits and Disputes. If you are involved in certain lawsuits or administrative disputes, we may disclose medical information about you in response to a court or administrative order.
9. Law Enforcement. We may release medical information if asked to do so by a law enforcement official in response to a court order or subpoena.
10. Electronic Disclosure. We may use and disclose your medical information electronically. For example, your medical information is maintained on an electronic health record. If another provider requests a copy of your medical record for treatment purposes, we may forward such record electronically.

DISCLOSURES REQUIRING AUTHORIZATION

1. Marketing. Marketing generally includes a communication made to describe a health-related product or service that may encourage you to purchase or use the product or service. We will obtain your authorization to use and disclose your medical information for marketing purposes unless the communication is made face-to-face, involves a promotional gift of nominal value, or otherwise permitted by law. All other uses and disclosures of your information for marketing purposes requires your written authorization. You have the right to revoke such authorization in writing.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

You have the following rights regarding medical information collected and maintained about you:

1. **Right to Inspect and Copy.** The right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to us. You can also ask to see or get an electronic copy of health information we have about you. Ask us how to do this.
2. **Right to Amend.** If you feel that medical information maintained about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by us. To request an amendment, your must be made in writing and submitted to us. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
   - Was not created by us, unless the person or entity that created the information is no longer available to make the amendments;
   - Is not part of the medical information kept by us
   - Is not part of the information which you would be permitted to inspect and copy; or
   - Is accurate and complete
3. **Right to an Accounting of Disclosures.** To request an "accounting of disclosures". This is the list of the disclosures made of your medical information for purposes other than treatment, payment or health care operations. To request this list you must submit your request in writing to us. Your request must state a time period, which may not be longer than six (6) years. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free.
4. **Right to Request Restrictions.** To request a restriction or limitation on the medical information we use or discloses about you for treatment OR payment. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care. Neither we, nor any are required to agree to your request, but should any of us agree to your request, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions you must make your request in writing and include (1) what information you want

to limit; (2) whether you want to limit our use and/or disclosure; and (3) to whom you want the limits to apply.

5. **Right to Revoke an Authorization.** There are certain types of uses or disclosures that require your express authorization. We may not sell your information to a third party for marketing purposes without first obtaining your authorization. If you provide authorization for a particular use or disclosure of your medical information, you may revoke such authorization in writing by contacting us. We will honor your revocation except to the extent that we have already taken action in reliance of the specific authorization.
6. **Right to Receive a Copy of this Document.** You have the right to obtain a paper copy of this document upon request.

CHANGES TO THIS NOTICE

We reserve the right to change our practices and to make the new provisions effective for all medical information we maintain. Should our information practices change, we will post the amended Notice of Privacy Practices in our office, You may request that a copy provided to you by contacting us.

I understand and agree to this Notice of Privacy Practices that was presented to me. I acknowledge that a copy will be made available if I request one. I ALSO CONSENT to receive telephonic sales and/or marketing calls, text messages, artificial or pre-recorded voice messages, and voice mail transmissions ("Call and Texts") to the first telephone number provided above, including using an automatic telephone dialing system or an automated system for the selection or dialing of telephone numbers or the playing of a recorded message, by or on behalf of affiliates, vendors and agents regarding its products and services. I authorize these telemarketing Calls and Texts even if I have previously included my telephone number(s) on any Do-Not-Call registry or list. I understand I am not required to provide this consent as a condition of purchasing any products or services. I have the authority to provide this consent. Message and data rates may apply.

_____

(Patient Printed Name)

_____ _____

(Patient or Legal Guardian Signature) (Date)

_____ _____

(Witness / Employee Signature) (Date)

PATIENT ACTIVITY ASSESSMENT

CHIROFIT ADVANCED RECOVERY

Name: _____ Today's Date: _____

Occupation: _____ Age: _____

The purpose of this form is to assist the doctor in better understanding your daily activities, your ability to perform them, and how they relate to the function of your body. Your answers will provide important information in establishing a customized plan of care designed to place you on the path toward attaining and maintaining your health care goals.

STANDING OR SITTING

Do you primarily stand or sit at work? ☐ Yes ☐ No

Approximately how many hours per week?

☐ 0-20 hours ☐ 20-40 hours ☐ 40+ hours

Are those primarily spent:

On the phone: ☐ Cell ☐ Desktop Phone ☐ Headset ☐ No Headset

Typing at a keyboard: ☐ Laptop ☐ Desktop Computer

☐ Other: _____

What is your most common posture?

☐ Sitting upright ☐ Slouched ☐ Crossed Legs ☐ Stand

Does your work require you to?

☐ Bend ☐ Twist ☐ Lift ☐ Carry ☐ N/A

What type of shoes do your wear in a regular basis?

☐ Dress ☐ Heels ☐ Running ☐ Boots ☐ Athletic ☐ Sandals

☐ Other: _____

Do you wear orthotics? ☐ Yes ☐ No

SLEEPING

What type of bed do you sleep on?

☐ Memory Foam ☐ Adjustable Firmness ☐ Inner Spring

☐ Other: _____

How many hours of sleeps do you get at night?

☐ 8 hrs or less ☐ More than 8 hrs

What position do you sleep in?

☐ Back ☐ Stomach ☐ Side ☐ AllDo

You regularly wake up with any back stiffness? ☐ Yes ☐ No

Do you regularly wake up with any neck stiffness? ☐ Yes ☐ No

BODY STRESSORS

Do your daily activities require you to lift and/or carry objects? ☐ Yes ☐ No

If yes, how often? ☐ Occasionally ☐ Frequently ☐ Constant

If yes, how approximately, how heavy?

☐ 10 lbs or less ☐ 10-30 lbs ☐ Over 30 lbs

Do you exercise? ☐ Yes ☐ No

If yes, approximately, how many days per week?

☐ 0-1 day(s) ☐ 1-3 days ☐ 3+ days

Type(s) of exercise:

Weight Training: ☐ Free Weights ☐ Machines ☐ Others: _____

Cardio Training: ☐ Eliptical ☐ Treadmill/Running ☐ Others: _____

Do your participate in sports: ☐ Yes ☐ No

If yes, please indicate all that apply?

☐ Skiing ☐ Body Building ☐ Soccer ☐ Tennis ☐ Walking/Hiking

☐ Volleyball ☐ Racquetball ☐ Yoga ☐ Dancing ☐ Cycling/Biking

☐ Golf ☐ Football ☐ Basketball

☐ Other: _____

Do you have a children at home? ☐ Yes ☐ No

If yes, how many? ☐ 1 ☐ 2 ☐ 3 ☐ More than 3: _____

Do any of your children require you to carry them? ☐ Yes ☐ No

CHIROPRACTIC ACTIVITY ASSESSMENT

Did You Know: the absence of pain is not an indication of health? ☐ Yes ☐ No

Did You Know: pain has a cause and many times that cause begins in the spine ☐ Yes ☐ No

Did You Know: over-the-counter pain medications and/or prescriptions may only mask the pain? ☐ Yes ☐ No

Did You Know: your daily activities can cause joint pain and dysfunctions in the spine and extremities? ☐ Yes ☐ No

Did You Know: these joint dysfunctions can cause decreased joint motion and function in the body? ☐ Yes ☐ No

Did You Know: decrease joint motion can also affect your ability to enjoy a healthy and active lifestyle? ☐ Yes ☐ No

Did You Know: the health benefits of routine chiropractic care may include any of the following: ☐ Yes ☐ No

1. Improved nerve communication
2. Improved joint motion
3. Improved joint coordination
4. Improved physical function
5. Improved physical performance
6. Improved posture
7. Increased daily activities
8. Provide pain and stress relief