Patient Intake Form

Patient Label

Interviewer: ____________________

Office: ____________________

PLEASE PRINT & USE BLACK INK

COMPLETE PAGES 1-6

PATIENT INFORMATION

Name: ____________________ Date: ____________________

Date of Birth: ____________________ Social Security #: ____________________

Street Address: ____________________

City: ____________________ State: ____________________ Zip: ____________________

Home Phone: ____________________ Cell Phone: ____________________

E-Mail Address: ____________________

Occupation: ____________________ Employer: ____________________ ❑ **Unemployed**

Employer: ____________________ Business Phone: ____________________

Employer Address: ____________________ Length of Employment: ____________________

Employer: ____________________ Business Phone: ____________________

Second Employer Address: ____________________

Sex: ❑ Male ❑ Female Height__________ Weight __________ Dominant Hand: ❑ Left ❑ Right

Race: ❑ African American ❑ Asian ❑ Caucasian ❑ Hispanic ❑ Other

Are you: ❑ Married ❑ Single ❑ Domestic Partnership ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: ____________________

Emergency Contact Name: ____________________ Relationship: ____________________

Contact Phone: ____________________

Name of nearest relative not living with you: ____________________ Phone: ____________________

PRIVATE HEALTH INSURANCE INFORMATION

Health Insurance Carrier: ____________________ Waiver Signed: ____________________

Health Insurance Address: ____________________

Policy Number: ____________________ Group Number: ____________________

Policy Holder: ____________________ DOB of Policy Holder: ____________________

Employer of Policy Holder: ____________________ Relationship: ____________________

Patient's Signature: ____________________

EXCELSIA
INJURY CARE

Patient Intake Form

ACCIDENT INFORMATION

How were you injured? ❑ Auto ❑ W/C ❑ Slip & Fall ❑ Auto/While on Job ❑ Cab/Uber/Lyft ❑ Bus

❑ Motorcycle ❑ Pedestrian ❑ Other: ______________________________

Date of Injury: ____________ What State? ____________ What County? ____________

Brief description of how injury/accident happened: ______________________________

Did you strike your head or any other part of your body in this accident? ❑ Yes ❑ No

What body parts?______________________________

Did you lose consciousness? ❑ Yes ❑ No

Have you been able to work since your accident? ❑ Yes ❑ No Last day worked? ____________

Has an out of work slip been issued to you? ❑ Yes ❑ No

AUTO ACCIDENT:

Were you the driver? ❑ Passenger? ❑ Seat Belted? ❑ Yes ❑ No Airbag Deploy? ❑ Yes ❑ No

Did the police or an ambulance come to the scene? ❑ Yes ❑ No

Has this accident been reported to the auto insurance company? ❑ Yes ❑ No

What part of the vehicle was struck? ______________________________

Driver's Name: ____________ Policy Holder's Name: ____________

Policy Holder's car insurance carrier: ______________________________

Policy Holder's Phone Number: ______________________________

PIP Adjuster: ____________ Phone #: ____________ PIP Claim #: ____________

IF YOU DO NOT OWN A MOTOR VEHICLE:

Does anyone else in household own a motor vehicle? ❑ Yes ❑ No

Workers Compensation:

Date of Injury: ____________ WC Carrier: ____________ Claim#:____________

Who is/was your employer at the time of injury?______________________________

Employer Address: ______________________________

(City) *(State)* *(Zip)*

Employer Phone Number: ____________ Supervisor's Name: ____________

Have you filed a "First Report of Injury" with your employer? ❑ Yes ❑ No

Patient's Signature: ______________________________

EXCELSIA
INJURY CARE

Patient Intake Form

Prior Accidents: Have you ever been in an accident prior to this current accident? ❑ Yes ❑ No

If Yes, when did the accident happen? ______________________________

Please give brief description of the *previous* accident: ______________________________

____

PRESENT HEALTH

Why do you need an evaluation today? Check the appropriate area and briefly explain.
(Examples-pain, numbness, tingling, burning, weakness)

❑ Neck ❑ Shoulder ❑ Elbow ❑ Wrist ❑ Low Back ❑ Hip ❑ Knee ❑ Leg ❑ Ankle ❑ Foot

❑ Other (please specify): ______________________________

____

When did the symptom(s) begin? ______________________________

How did the pain symptom(s) start? Check the appropriate response or explain.

❑ Suddenly ❑ Gradually ❑ Twisting ❑ Pulling ❑ Fall ❑ Lifting ❑ Bending ❑ Hit by Object

❑ Sports ❑ No Apparent Cause: ______________________________

Did you go to the hospital, E.R., or Urgent Care? ❑ Yes Date(s):______________ ❑ No

Name of hospital, E.R. or Urgent Care:______________________________

Did you have X-rays, MRI, CT scan, or other diagnostic testing? ______________________________

Have you been treated anywhere else for this accident? ❑ Yes ❑ No (If Yes, please provide the name of the facility)

____

Have you ever been treated at a pain management facility? ❑ Yes ❑ No

If yes, where?______________________________ Phone Number: ______________________________

Have you been injured prior to this accident? ❑ Yes ❑ No

Have you ever had a Disability Rating for a previous accident? ❑ Yes ❑ No

Please list any medications you are currently taking: ______________________________

____

Please list any supplements you are currently taking: ______________________________

Are you currently using medical marijuana? ❑ Yes ❑ No If Yes, What has it been prescribed for?

____

Please list any allergies (including drug and latex allergies) you may have: ______________________________

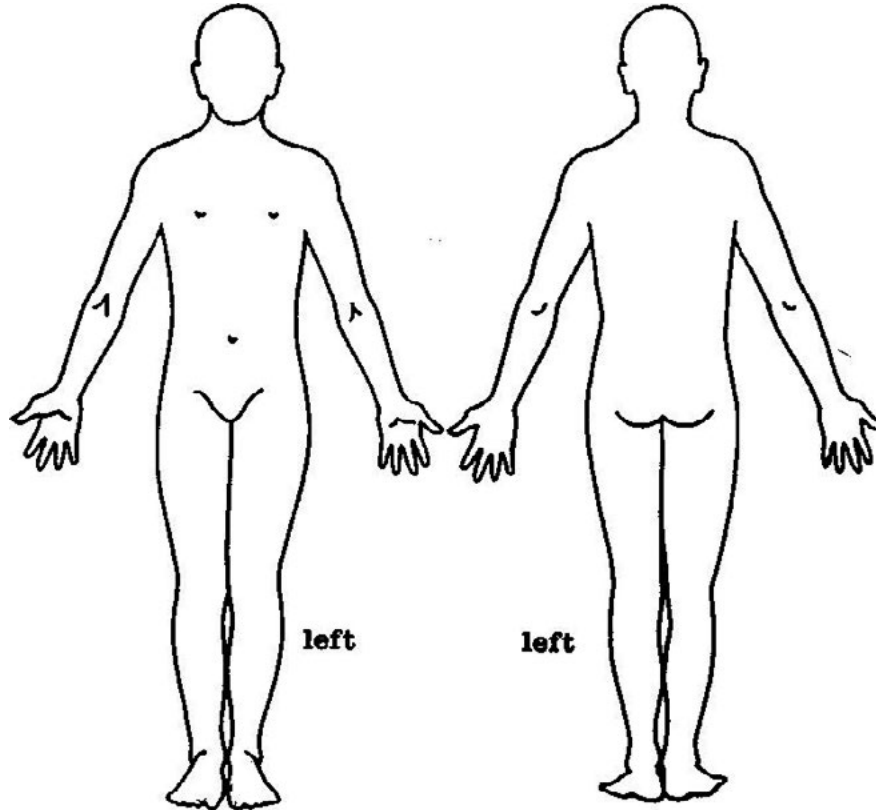
____

Patient's Signature: ______________________________

EXCELSIA INJURY CARE

Patient Intake Form

PAIN DESCRIPTION
Use the pictures below to indicate your problem areas. Use an X to mark areas of pain.



REVIEW OF SYSTEMS

Weight: ________________ Weight 1 yr. Ago: ________________ Max. Weight: ________________ When: ________________

MEDICAL HISTORY:
Please mark any of the symptoms that apply to you **TODAY**:

Abdominal Pain ❑ Yes ❑ No
Muscle Weakness ❑ Yes ❑ No
Anxiety ❑ Yes ❑ No
Numbness or Tingling ❑ Yes ❑ No
Chest Pain ❑ Yes ❑ No
Painful or Urgent Urination ❑ Yes ❑ No
Cough ❑ Yes ❑ No
Rapid Heart Beat ❑ Yes ❑ No
Cuts that won't stop bleeding ❑ Yes ❑ No
Rash ❑ Yes ❑ No
Depression ❑ Yes ❑ No
Shortness of Breath ❑ Yes ❑ No

Fever/Chills ❑ Yes ❑ No
Swelling of Legs ❑ Yes ❑ No
Frequent Urination ❑ Yes ❑ No
Vomiting ❑ Yes ❑ No
Frequent/Easy Bruising ❑ Yes ❑ No
Discolored Stools ❑ Yes ❑ No
Irregular Heart Beat ❑ Yes ❑ No
Wound Healing Problems ❑ Yes ❑ No
Joint Pain or Swelling ❑ Yes ❑ No

Other: ____

____

Patient's Signature: ____

EXCELSIA
INJURY CARE

Patient Intake Form

Check if you have had any of these conditions in the **PAST** or if there is any **family history of these conditions**:

Anemia ❑ Self ❑ Family
Arthritis ❑ Self ❑ Family
Heart Arrhythmia/Palpations ❑ Self ❑ Family
Heart Arrhythmia/Palpations ❑ Self ❑ Family
Asthma ❑ Self ❑ Family
Bleeding Problems ❑ Self ❑ Family
Blood Clots ❑ Self ❑ Family
Cancer:______________________________ ❑ Self ❑ Family
Chest Pain/Angina ❑ Self ❑ Family
Claustrophobia ❑ Self ❑ Family
Diabetes ❑ Self ❑ Family
Gall Bladder Disease ❑ Self ❑ Family
Gastric Ulcers ❑ Self ❑ Family
Glaucoma ❑ Self ❑ Family
Heart Attack ❑ Self ❑ Family
Heart Failure ❑ Self ❑ Family
Hepatitis B ❑ Self ❑ Family
Hepatitis C ❑ Self ❑ Family
High Blood Pressure ❑ Self ❑ Family
HIV/AIDS ❑ Self ❑ Family
Immune Deficiency ❑ Self ❑ Family
Liver Disease ❑ Self ❑ Family
Kidney Disease ❑ Self ❑ Family
Loss of Vision ❑ Self ❑ Family

Neuropathy ❑ Self ❑ Family
Osteoporosis ❑ Self ❑ Family
Osteopenia ❑ Self ❑ Family
Paralysis ❑ Self ❑ Family
Peripheral Vascular Disease ❑ Self ❑ Family
Pneumonia ❑ Self ❑ Family
Psychiatric Illness ❑ Self ❑ Family
Pulmonary Embolism ❑ Self ❑ Family
Reflux ❑ Self ❑ Family
Rheumatoid Arthritis ❑ Self ❑ Family
Skin Ulcer/Breakdown ❑ Self ❑ Family
Steroid Use ❑ Self ❑ Family
Stroke ❑ Self ❑ Family
Thyroid Disease ❑ Self ❑ Family
Tuberculosis-TB ❑ Self ❑ Family
Heart Murmur ❑ Self ❑ Family
Urinary Infections ❑ Self ❑ Family
Valve Disorders (Heart) ❑ Self ❑ Family
Wound Healing Problems ❑ Self ❑ Family
Orthopaedic Conditions:______________________________
❑ Self ❑ Family

Other: ____

____

SURGICAL HISTORY

Please list any surgeries and the dates they were performed:

Date: __________________ Surgery: ____

Date: __________________ Surgery: ____

Date: __________________ Surgery: ____

Date: __________________ Surgery: ____

Date: __________________ Surgery: ____

Patient's Signature: ____

EXCELSIA
INJURY CARE

Patient Intake Form

SOCIAL HISTORY

Do you have Children?
❑ Yes – How many: ____________ ❑ No

Are you Pregnant? *(Women Only)*
❑ Yes ❑ No

Do you Live Alone?
❑ Yes ❑ No

Drugs/Alcohol:
History of Substance Abuse?
❑ Yes ❑ No

Do you drink Alcoholic Beverages?
❑ Yes – How many: ____________ ❑ No

Do you smoke Cigarettes?
❑ Yes – How much: ____________ ❑ No

If you smoked in the past, how long has it been since you stopped?
❑ 0-3 months ❑ 3-6 months ❑ 6-12 months ❑ Over a year ago

Exercise:
Do you Exercise?
❑ Daily ❑ Weekly ❑ Monthly ❑ Rarely ❑ Never

What type of Exercise?
❑ Walking ❑ Running ❑ Swimming ❑ Weight Lifting ❑ Aerobics
❑ Other: ____

Patient's Signature: ____

General Consent for Evaluation and Treatment

Welcome to Excelsia Injury Care. At this point in your care, no specific treatment plan or procedure has been recommended. This consent form is simply to obtain your permission to perform the evaluation necessary to identify any condition that might require an appropriate treatment or procedure as part of your plan of care. You have the right to be informed about any condition identified and the options for recommended procedures to be used. You may then decide whether or not to undergo any suggested treatment or procedure after being informed of the potential benefits and risks involved.

This consent provides our medical staff (consisting of medical doctors, chiropractors, physician assistants, and nurse practitioners and physical therapists) with your permission to perform reasonable and necessary examinations, testing, and treatment. By signing below, you are indicating that you understand that this consent is continuing in nature and will remain fully effective until it is revoked in writing. You have the right at any time to ask additional questions or to discontinue or decline services.

You have the right to discuss the treatment plan with your provider. If you have any concerns regarding any test or treatment recommended by your provider, we encourage you to ask questions. If additional testing, invasive, or interventional procedures are recommended, you will be asked to read and sign additional consent forms prior to any such tests or procedures.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to their contents.

______________________________	______________________________
Signature of Patient or Representative	**Date**
______________________________	______________________________
Printed Name of Patient or Representative	**Relationship to Patient**

Notice of Financial Policies and Billing Practices

Please carefully read the following paragraphs and initial each paragraph in the space provided. If you consent to each of the following, please sign and date this form as indicated below.

_____________ **Statement of Financial Policy:**

The providers and staff of Excelsia Injury Care are very concerned about the cost of your healthcare. Considerable care has been taken in setting our fees. We want to assure you that our charges accurately reflect the complexity of care rendered and the skill and expertise for your care. Our fees are comparable with the fees for similar specialties within the area where services are rendered. We use many sources to determine the appropriateness of our fees. Excelsia Injury Care will submit your claim to your insurance company on your behalf; however you are ultimately responsible for the service you receive.

_____________ **Assignment of Benefits/Guarantee of Payment:**

By initialing here and signing below, you hereby authorize direct payment to Excelsia Injury Care of any insurance, personal injury, or other benefits otherwise payable to you for any services rendered. You further give a lien on your case to Excelsia Injury Care against any and all proceeds of settlement, judgment or verdict which may be directly paid to you or your attorney as a result of the injuries for which you have been treated, including any proceeds from any medical insurance, personal injury protection, or medical payment coverage you receive in connection with your case. You authorize and direct your attorney to withhold any sums from any settlement, judgment or verdict as may be necessary to adequately protect Excelsia Injury Care and to pay Excelsia Injury Care directly for services rendered. You authorize your attorney(s) to notify Excelsia Injury Care at Excelsia Injury Care's request of any substantial change in the cause of action related to the illness or injuries you have suffered that would affect your ability to pay for health care services rendered by Excelsia Injury Care.

_____________ **Payment Courtesies Extended Not Binding:**

You acknowledge that, if Excelsia Injury Care allows you to delay payment in anticipation of third-party reimbursement, including any funds procured from a settlement, such forbearance is a courtesy only, and such courtesy may be withdrawn at any time upon notice to you. If Excelsia Injury Care does not offer you a delayed payment courtesy, then you understand that payment for services rendered is payable in full at the time of service. If a delayed payment courtesy is offered, but subsequently withdrawn, then payment for all services rendered may become due upon demand by Excelsia Injury Care. You grant Excelsia Injury Care a power of attorney to collect these sums on your behalf, and agree never to rescind this document and that a recession will not be honored by your attorney. You

hereby instruct that in the event that another attorney is substituted in the matter, the new attorney will honor the lien as inherent to the settlement, judgment or verdict and enforceable upon the case as if it were executed by him. You agree to

notify Excelsia Injury Care in writing if you change or substitute your attorney, and you authorize your attorney to notify Excelsia Injury Care should their representation of you terminate for any reason.

______________ **Financial Responsibility:**

You are financially responsible for all medication once you leave the office, even if you decide that you do not want the medication. Excelsia Injury Care will not issue a refund for unused or unwanted medications. You hereby acknowledge responsibility for any health insurance deductible, coinsurance, or other sum not paid by an insurance carrier or any other third-party for any reason, payable upon demand by Excelsia Injury Care. Excelsia Injury Care may discontinue treatment if timely payment of any sum owed is not made when requested. A late fee of one-half percent (.5%) per month may be charged to unpaid balances remaining after thirty (30) days from the date payment is due. In the event that the account is referred to collections, you agree to pay all reasonable collection and attorney fees required to collect any delinquent balance. In the event that any insurance company that is obligated by law or contract to make payment for medical services refuses to make such payments, in whole or in part, you assign Excelsia Injury Care your rights to any cause of action that exists against any such insurance company in your name and to settle or otherwise resolve any such action as Excelsia Injury Care deems fit.

______________ **Physician/Facility Charges:**

In addition to any bills you may receive pertaining to physician's professional fees, you may also receive a separate facility bill, in the event that a third-party facility (I.e. surgery center) is involved in your care, the amount of which may be ascertained by contacting the facility in advance of presenting there.

______________ **Supplemental Income Insurance Forms:**

During the time of your disability, you may have insurance forms you will need us to complete in order to get certain bills paid. These bills could include your mortgage payment, car payment, credit cards, etc. As a courtesy to you, our patient, we will be happy to complete these forms for you. We will fill out the first of these forms at no cost to you. After the first form there will be a cost of $11.00 per form, which is your responsibility, payable by credit card. You must complete as much of the form as you can, and allow us five (5) business days to complete. We will call you when the form is ready and you may stop in the office to pick up the completed form. If you want the form mailed to you, you must provide us with a self -addressed, stamped envelope. We will return the form to you as soon as it is completed.

[Signature page follows]

I certify that I have read and fully understand the above statements and consent fully and voluntarily to their contents.

______________________________	______________________________
Signature of Patient or Representative	**Date**
______________________________	______________________________
Printed Name of Patient or Representative	**Relationship to Patient**

Notice of Privacy Practices; Consent to Electronic Communications

Please carefully read the following paragraphs and initial each paragraph in the space provided. If you consent to each of the following, please sign and date this form as indicated below.

______________ **Patient Rights and Responsibilities/Notice of Privacy Practices:**

I acknowledge that I am in receipt of Excelsia Injury Care Patient Rights and Responsibilities and Notice of Privacy Practices.

______________ **Authorization for Tri County to Release/Access Information:**

I hereby authorize Excelsia Injury Care to release, via hard copy or electronically, my diagnosis and other medical information to my attorney; also to release copies of any other medical reports we procure from other sources, regarding my current injury as well as any prior medical records, as requested. Upon release to my attorney, Excelsia Injury Care is not responsible for the use or release of this information pursuant to this authorization. I understand that the providers of Excelsia Injury Care may access my medication history by using Health Information Exchange (HIE) & the Prescription Drug Monitoring Program (PDMP). With the exception of the controlled substance clinical data reported to the PDMP, I may revoke this authorization at any time by submitting a request in writing to Excelsia Injury Care.

______________ **Authorization for PriorityCare Rx to Release/Access Information:**

Excelsia Injury Care has a relationship with PriorityCare Rx, a mail-order pharmacy service I may use for the fulfillment of medications prescribed to me in the course my treatment at Excelsia Injury Care. I understand I may choose to fulfill my prescriptions at a pharmacy of my choosing and am not required to use PriorityCare Rx for my prescriptions. By signing this document, I acknowledge that if I choose to use PriorityCare Rx for my prescriptions, I hereby authorize PriorityCare Rx to release, via hard copy or electronically, information related to my prescription medications, diagnosis, and treatment plan to my attorney. Upon release to my attorney, neither PriorityCare Rx nor Excelsia Injury Care is responsible for the use or release of such information pursuant to this authorization. I may revoke this authorization at any time by submitting a request in writing to Excelsia Injury Care.

______________ **Electronic Communications:**

By signing this document, I give permission to Excelsia Injury Care to leave messages regarding my appointments on my answering machine or with a responsible person answering my home phone. Also, by signing this document, I understand that I came opting-in to receive automated email and/or text messages to the email and/or phone number(s) I have provided. Message/data rates will apply. By agreeing to accept these text messages, I acknowledge and understand that SMS text messaging is not a secure

form of communication and there is some risk that a text containing personal health information (PHI) may be disclosed to, or intercepted by, unauthorized third parties. Excelsia Injury Care will NOT text me sensitive information such as actual diagnostic results, but will simply notify me via text that additional information is available and that I should contact Excelsia Injury Care at my convenience. I may opt out at any time by replying "STOP" to the text. I understand that Excelsia Injury Care providers cannot engage in two-way text messaging.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to their contents.

______________________________	______________________________
Signature of Patient or Representative	**Date**
______________________________	______________________________
Printed Name of Patient or Representative	**Relationship to Patient**

Notice of Beneficial Interest

During the course of your treatment at Excelsia Injury Care you may need diagnostic tests to give your treating provider important information about your illness/injury. Subsequently, additional treatment or surgery may be required. We have facilities to provide some of these additional services. You may choose to have the services performed at our centers or anywhere you like.

Please be advised that Excelsia Injury Care providers Scott Pello, M.D, Bradley Ferrara, M.D., and Constantine Misoul, M.D. have a beneficial interest or compensation arrangement with PriorityCare Rx, LLC, a mail order pharmacy associated with our practice. In addition, Constantine Misoul, M.D., has a beneficial Interest or compensation agreement with Excelsia Injury MRI, formerly known as Multi Specialty MRI.

Scott Pello, M.D., has a beneficial interest or compensation relationship with the following surgical facilities:

- Ambulatory Surgery Center of Bala Cynwyd, PA located at 100 Presidential Blvd., Floor 4, Bala Cynwyd, PA 19004.
- Huntingdon Valley Surgical Center, located at 1800 Byberry Road, Bldg. 10, Huntingdon Valley, PA 19006.
- Main Line Surgery Center, located at 10 Presidential Blvd., Suite 102, Bala Cynwyd, PA 19004.

Please also be advised that Mark Paiste, D.O. has a beneficial interest or compensation relationship with Advanced Surgical Institute located at 556 Egg Harbor Road, Suite B, Sewell, NJ 08080.

Several Excelsia Injury Care Centers offer In-house medication dispensing services ("In-house Pharmacy") to fill the prescriptions that your treating physician prescribed for you. Your Excelsia treating physician's employer and/or your treating physician has a financial interest In the In-house Pharmacy.

If you would like to receive your additional service(s) at a different provider of any of these services in your community, please let us know and we will happily refer you.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to their contents.

______________________________	______________________________
Signature of Patient or Representative	**Date**
______________________________	______________________________
Printed Name of Patient or Representative	**Relationship to Patient**

Notice of Office Policies

This document sets forth Excelsia Injury Care office policies and is provided to you as a courtesy and convenient reference. If you have any questions or concerns regarding these policies, please do not hesitate to notify Excelsia Injury Care staff or your provider, who will be happy to assist you.

______________ **Scheduled Appointments:**

Please make every effort to arrive on time for your scheduled appointments. If you should arrive late for your appointment, we will make every attempt to see you, but our staff will care for patients that arrive on time, prior to caring for you.

______________ **Personal Valuables:**

Patients are encouraged to leave all money and valuables at home. Excelsia Injury Care shall not be responsible for the loss of or damage to any personal property brought into Excelsia Injury Care inclusive of glasses, dentures and jewelry.

______________ **Use of Electronic Devices**:

To ensure confidentiality and privacy the use of all electronic devices is prohibited at any location within our offices. These devices include, but are not limited to, cell phones, portable tablets or any other type of recording device.

______________ **Physician Assistants & Supervising Physicians:**

Our medical staff consists of licensed physician assistants and/or nurse practitioners, who routinely render treatment to our patients under the supervision of a physician. Treatment by a physician assistant and/or a nurse practitioner under the supervision of a physician may include the prescribing and dispensing of medications.

______________ **Prescription Services:**

As the patient, you may obtain medications here, if a pharmacy is not conveniently located to you. Please inform your provider of your preference when medications are discussed during your visit.

______________ **Obtaining Copies of MRI Scans:**

Should you need to obtain a copy of your MRI, please call the facility where the MRI was performed. Please allow 48 hours for the copy to be produced.

[Signature page follows]

I certify that I have read and fully understand the above statements and consent fully and voluntarily to their contents.

______________________________	______________________________
Signature of Patient or Representative	**Date**
______________________________	______________________________
Printed Name of Patient or Representative	**Relationship to Patient**

Chiropractic Informed Consent

Please read this entire document prior to signing.

It is important that you understand this information in order to make an informed decision about your health care options. Please ask any questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment

The primary treatment used by Doctors of Chiropractic (DC) is referred to in the health care research literature as adjustments/manipulations/joint mobilizations. This involves the use of the hands, or a mechanical instrument, to mobilize the affected joint structures.

Adjunctive therapies

In addition to the adjustments your chiropractor, and their assistants, have undergone additional training, and separate licensure, to provide physical therapy modalities which may be performed by them to assist in your recovery and overall improved health. The modalities vary from office to office, but all such services which may be rendered by them provided have been approved, and are regulated, by the given state board with which Excelsia Injury Care chiropractors are licensed.

Analysis/Examination

In order to arrive at a working diagnosis of your particular condition you are hereby consenting to undergo various evaluation procedures including, but not limited to consultation, vital signs, range of motion testing, palpation, orthopedic/neurologic testing, postural analysis, muscle strength testing and radiologic studies. Depending on the results of the evaluation it may be necessary to refer you for additional diagnostic testing or consultation with a medical provider. **When completing your Patient Intake Form it is necessary to provide a thorough recollection of your past medical history**. This information is important in helping your doctor determine the best clinical course of action for your well-being.

The material risks inherent in the chiropractic adjustment

As with any health care procedure, there are certain complications which may arise during the chiropractic manipulation and adjunctive therapies**. Although these risks are rare** they do include, but are not limited to fractures, disc injuries, dislocations, muscle strains, cervical myelopathy, costovertebral strains and burns. It is not uncommon for some patients to feel some stiffness and soreness following the initial few days of treatment.

Some types of cervical manipulation have been associated with injuries to the vertebral arteries leading to, or contributing to, serious complications including stroke. This form of incidence is extremely rare occurring about one time per 1-2 million procedures. While these complications

have been the subject of ongoing research and debate, a causal relationship is extremely rare and remote.

Chiropractic treatment has been the subject of research conducted over many years and has been demonstrated to be an appropriate and effective form of treatment for spine and joint pain and other similar symptoms. Chiropractic care has also been found to contribute to your overall well-being. The risk of complications are substantially lower than the risks associated with many medications and alternative treatments for the same types of musculoskeletal conditions.

During the examination the doctor will make every reasonable effort to screen for contraindications to care. However, if you have a condition that would otherwise not come to the doctor's attention it is your responsibility to inform the doctor. Your Doctor of Chiropractic will evaluate your individual case, provide an explanation of care and suggested treatment plan, or alternatively refer you for consultation and/or further evaluation if deemed necessary.

The availability and nature of other treatment options

As a multi-disciplinary health care practice we at Excelsia Injury Care recognize the benefits other treatment options that we provide, in conjunction with your chiropractic treatments. These options are outside the scope of chiropractic, but may be provided by members of our medical staff or your personal physician. These options include:

- Self-administered over the counter analgesics and rest.
- Medical care and prescription drugs such as anti-inflammatories, muscle relaxants, and pain relievers.
- Hospitalization.
- Surgery
- If you choose to use one of the other treatment options noted above you should be aware that there are risks and benefits of such options and you may wish to discuss these with your medical physician.

Indirect Supervision of Certified Chiropractic Assistants

During the course of your treatment our Doctor of Chiropractic may be assisted by Certified Chiropractic Assistants (CCA's). In such an event, all of whom have been approved by the given state Board of Chiropractors to assist in your treatment. In given states, our CCA's are authorized by the state Board of Chiropractors to for short durations of time begin your treatment without the

Doctor of Chiropractic on the premises, which is referred to as Indirect Supervision. Our company protocol is that such Indirect Supervision shall only be utilized if the Doctor of Chiropractic's arrival is delayed for short period of time and only when the Doctor of Chiropractic is immediately available by telephone. If you are provided with treatment via Indirect Supervision it shall not exceed 10% of your total treatment time in any given 30 day period.

I understand and accept:

- I have the right to withdraw from or discontinue treatment at any time and the practice providers will advise me of any material risks in those regards. Delaying, or discontinuing, treatment may have deleterious effects to my health for which I accept full responsibility.
- That neither the practice of chiropractic, nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor during the course of my care.
- That it is not reasonable to expect the doctor to be able to anticipate or explain all risks or complications. An undesirable result does not necessarily indicate an error in judgment or treatment.
- The practice does not guarantee as to results with respect to any course of care or treatment.
- My care and treatment will not be observed or recorded for any non-therapeutic purpose without my consent.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment I may receive. I have had the opportunity to ask questions and discuss my care with the Doctor of Chiropractic (DC). My signature below acknowledges my consent to the examination and proposed treatments to be provided by Excelsia Injury Care.

Patient Name: ___________________________________

Patient Signature: ________________________________

Date: ____

Guardian Name (If a minor): ________________________

Guardian Signature: ______________________________