Welcome to Beacon Health System Inc.

Filling out this paperwork thoroughly will help us give you the best possible care.

Last Name_____ First Name_____ Middle Initial_____

Name you prefer to be called_____ Sex_____ Marital Status_____

Address_____ City_____ State_____ Zip code_____

Referred by: _____ Employer: _____

Home phone_____ Mobil Phone_____

Work phone_____ Fax number_____

Email: _____ Can we contact you via Email? Yes/ No

Best # to reach you_____ Can we leave a message? Yes / No

Social Security #_____ Birthday_____ (month, day, year)

Would you like us to call you with special promotions? YES/NO

Other members of your household Relation Ages leave message?

_____

_____

Last seen for chiropractic care on_____ Cared for by DR._____

Approximate office location_____

Insurance Information

We will need to obtain a copy of your card, as we can't bill without it.

Primary Insurance Name_____ Relation to member_____

Primary Insured Name_____ DOB_____ SS#_____

Secondary Insurance Name_____ Relation of carrier_____

Secondary Insured Name _____DOB_____ SS#_____

SPECIALIST COPAY AMOUNT ON CARD $_____ Date that your deductible starts over_____

Do you believe that your deductible has been met for this billing year? (circle one) **YES NO**

Beacon Health System Inc.

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OF HEALTHCARE OPERATIONS

I_____ (*print patient name)*, understand that as a part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examinations and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and treatment information to my bill.
- A means by which a third- party payer can verify that services billed were actually provided.
- A tool for the routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Health Information Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change its notice and practices and, prior to implementation, will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent, in writing, except to the extent that the organization has already taken action in reliance thereon.

I wish to have the following restrictions to the use or disclosure of my health information:

I fully understand and *accept* the terms of this contract.

Patient/ Guardian Signature_____ **Date**_____

INFORMED CONSENT
DOCTOR – PATIENT RELATIONSHIP IN CHIROPRACTIC

CHIROPRACTIC
It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic health care services.

ANALYSIS
A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use this inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative power of the body.

DIAGNOSIS
Although doctors of chiropractic are experts in chiropractic diagnosis, the VSS and the VSC, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE
A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or health care, if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic provider is licensed in a special practice and is available to work with other types of providers in your health care regime.

RESULTS
The purpose of chiropractic services is to promote natural health through the reduction of the VSS or the VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometimes the response is phenomenal.

In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions which do not respond to chiropractic care may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

TO THE PATIENT
Please discuss any questions or problems with the doctor **BEFORE** signing this statement of policy.

I have read and understand the above information:

_____ _____

Patient/Guardian Signature **Date**

BEACON HEALTH SYSTEM INC.

INFORMED CONSENT BIO-MERIDIAN

Background: There is evidence to support a relationship between both conscious and subconscious stress and the electrical resistance of the skin. Therefore, procedures that monitor electrical resistance of the skin and changes in skin resistance provide useful indications of stress. **Bio-Meridian** systems are designed to help identify particular patterns associated with various types of stress reactions and agents which reduce those reactions.

Procedures: The procedure is totally non-invasive (the skin is not pierced). A metal probe is touched to the skin to measure electrical conductivity at responsive points, typically on the hands and feet. Nutritional supplements and other natural remedies are used to bring abnormal electrical patterns into equilibrium. This exam does not make any claim to diagnose or treat diseases of the body.

Risks: The procedure is very safe because it measures only changes in the electrical properties of the skin. However, since an electrical signal is used there is a slight risk of electrical burn or shock. The only discomfort commonly felt is where the stylus touches a location on the skin. Skin irritation or redness may occur at the site of the test. However, any discomfort should be brief. There are generally no risks associated with the substances recommended to bring your body to equilibrium as long as those substances are taken as recommended, but please report any discomfort you may experience to your examiner or physician. Please report any significant health problems (i.e. Diabetes, High Blood Pressure, etc.) to your physician.

Questions: Your examiner will answer any questions about Bio-Meridian that you may have. Please do not hesitate to ask any questions regarding Bio-Meridian.

Free to Decline: You are free to decline Bio-Meridian services, or to withdraw consent and to discontinue participation at any time without prejudice to you.

Important: There is no recognized body of scientific evidence to show that an electrically balanced body is more likely to be healthier and you have chosen to participate in this assessment with that understanding. Your physician may need to use other forms of testing in the course of your treatment.

Payment for Services: You are responsible for the payment of the normal and necessary fees associated with the Bio-Meridian and any remedies, supplements, or herbals recommended as a result of that testing, if purchased in this clinic.

I have read and understand the above information about Bio-Meridian and my rights and responsibilities and hereby consent to the use of the Bio-Meridian. It is further understood that the recommendations for Health & Wellness support is for the sole purpose of helping my body to heal naturally and not the treatment of symptoms or disease. Any information revealed during testing is not considered a diagnosis. I consent to the use of clinical reports and results of my case for study, the purpose of advancing clinical knowledge, research and scientific purposes provided that my identity is kept confidential.

Name: _____ Date:_____

(Please Print)

Signature of patient/ guardian:_____

ASSIGNMENT AND RELEASE

PLEASE READ BEFORE SIGNING!

I authorize release of my information to family physicians, insurance companies and my employer. I authorize the taking of photographs and x- rays to be used for treatment purposes. I authorize the performance of other diagnostic and therapeutic procedures, for treatment purposes. I understand that Dr. Orr and staff of Beacon Health System Inc. does not diagnose or treat diseases.

I AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO:

BEACON HEALTH SYSTEM INC.

I acknowledge that I am financially responsible for all services. I understand that if my care and treatment is terminated, any fees for professional services rendered to me will be immediately due and payable.

Patients Printed Name_____

Patient's signature _____Date_____

(Guardian's signature if patient is a minor)

Female patients: To the best of my knowledge I am not pregnant.

Patient's signature_____ Date_____

Permission & Authorization Regarding the use of Nutritional Response Testing

PLEASE READ BEFORE SIGNING:

I specifically authorize the natural health practitioner(s) at Beacon Health System Inc. to perform **Nutrition Response Testing,** health analysis and to develop a natural, complementary health improvement program for me which may include dietary guidelines, nutritional supplements, etc. in order to assist me in improving my health**, and not for the treatment or "cure" of any disease.**

I understand that **Nutrition Response Testing** is a safe, non- invasive, natural method of analyzing the body's physical and nutritional needs and that deficiencies or imbalance in these areas could cause or contribute to various health problems.

I understand that **Nutrition Response Testing** is not a method for "diagnosing" or "treating" of any disease including conditions of cancer, AIDS, Infections, or other medical conditions and that these are not being tested for or treated.

No promise or guarantee has been made regarding the results of **Nutrition Response Testing** or any natural health, nutritional or dietary programs recommended but rather I understand that **Nutritional Response Testing** is a means by which the body's natural reflexes can be used as an aid to determining possible nutritional imbalances so that safe, natural programs can be developed for the purpose of bringing about a more optimum state of health. **I have read and understand the foregoing.**

This permission form applies to subsequent visits and consultations.

Name_____

Signed:_____ Date:_____

(parent or guardian if patient is a minor)

ATTENTION: PLEASE BRING ALL SUPPLEMENTS YOU ARE CURRENTLY TAKING WITH YOU FOR EACH VISIT!

Beacon Health System Inc.

Office Policy

Please keep the appointments that you schedule, and call us to cancel if you need to. Our goal is to improve and maintain your health, however, you do need to show up for us to be able to help you.

Please sign in when you arrive. We attempt to honor all appointments at the scheduled time, and if you are late, we will see you, however, you may have to wait for the next available appointment time.

We **do** accept walk in appointments, in the order of arrival, assuming that there is adequate time to see you. We will try to be upfront about the possible waiting period.

Payment is due at the time that services are rendered. If you have health insurance, we can bill for your chiropractic care **AS A COURTESY!** However, billing is no guarantee of coverage, and once we bill, you are responsible for the balance as determined by your insurance company. If there is a co-pay stated on your card, we are considered a **SPECIALIST**, and we must collect that amount stated up front.

If you decide to pay out of pocket for your care, we are not able to Retro- bill any insurance. We can at any time give you a statement of your care and payments that you can submit to the insurance of your choice, or to a HSA/ Flex spending fund.

If your care is due to an auto accident, we will be billing YOUR auto insurance! They will bill the AT-FAULT PARTY. This is why you carry insurance.

If you have any questions regarding our office policy or your appointments, please do not hesitate to speak to our staff directly. THANK YOU!

Patient's Name: _____ Date:_____

Patient's Signature (or guardian if patient is a minor)

Ability Index Questionnaire

Name_____ Date_____

Date of Birth:_____ Current age:_____

Occupation:_____

Please describe your daily physical duties:_____

_____

_____

Major symptoms and complaints

_____

_____

Is this the first episode of pain?_____ When did it begin?_____

How long have you had this pain?_____yrs. _____mths. _____wks. ____ days

Circle the areas on your body where you experience pain. Use the key below to label the area with the type of sensation you feel. Thank you.

A = Ache

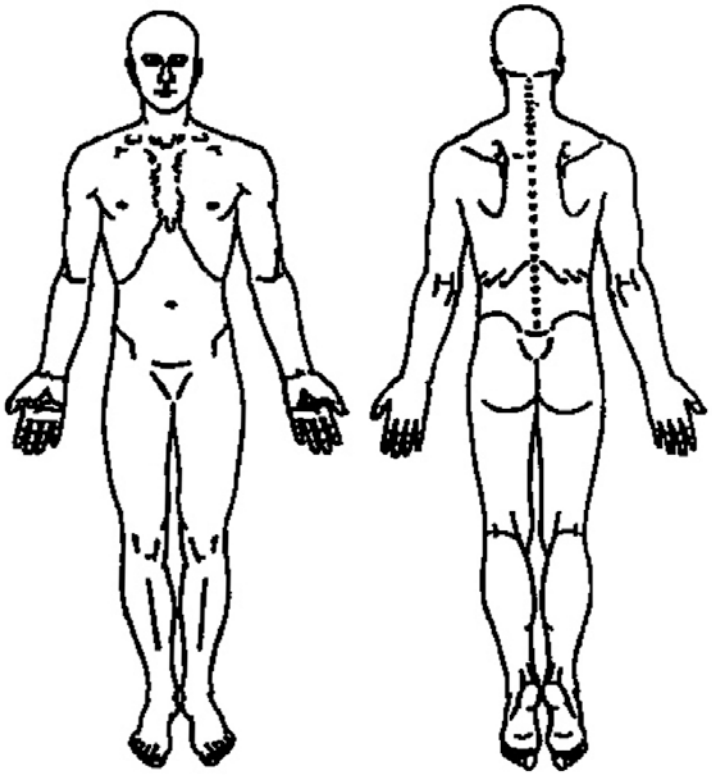
P= Pins and needles

B= Burning

S= Stabbing

N= Numbness

O=Other



Sign and Date!

Current Medications and Surgeries

Medication **Dosage** **Prescribed For?** **Duration**

_____

_____

_____

_____

Surgeries **Date** **Dr. / Hospital**

_____

_____

_____

_____

Family History

	Arthritis	Cancer	Diabetes	Heart Condition	Lung Disease	Depression	Stroke	Headaches	Anxiety Issues
You									
Mother									
Father									
Siblings									
Grandparents									

Please inform us of any other medical conditions that are part of your history.

_____

_____

_____

_____

Name:_____ Date_____