Informed Consent Document

PATIENT NAME: _____

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask 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 is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

- spinal manipulative therapy
- palpation
- vital signs
- range of motion testing
- orthopedic testing
- basic neurological
- muscle strength testing
- postural analysis testing
- acupuncture
- laser therapy
- nutritional supplements
- graston
- radiographic studies
- Other

Initial to consent to the above:_____

_____

_____

Patient should initial each procedure they are consenting to.

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination 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.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke and /or vertebral artery dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of a vertebral artery stroke.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

• Self-administered, over-the-counter analgesics and rest

• Medical care and prescription drugs such as anti-inflammatory, muscle

relaxants and pain-killers
• Hospitalization
• Surgery

If you chose to use one of the above noted "other treatment" options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

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 have discussed it with *Greenwich Wellness* and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

_____
Patient's Name

_____
Signature

_____
Signature of Parent or Guardian (if aminor)

GREENWICH WELLNESS
Dr. Adam Massoud
11 Maple Ave.
Greenwich CT 06830

Tele: (203) 637-1111
Fax: (203) 637-5956

Patient Name:_____ Date:_____

Cancellation/ Missed Appointment Policy

Your appointment time has been set aside for you. The time is unavailable to other patients. Therefore, we require at least 24 hours advanced notice if you need to cancel your appointment. For all missed or cancelled appointment with less than 24 hours' notice, you will be charged a $50 cancellation fee. Appointment reminder calls are a courtesy. Should you not receive a reminder telephone call; it is still your responsibility to remember your appointment.

I have read and understand the cancellation/missed appointment a policy

_____

(Patient Signature)

If Patient is a minor, please provide parent or guardian's information

Name _____ Relationship _____

Parent or Guardian signature _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

HIPPA Notice of Privacy Practices Notification

"I understand that Greenwich Wellness associates is legally permitted to use and disclose my protected health information ("PHI") for the purposes of treatment, payment and health care operations without my consent. Greenwich Wellness associates HIPAA Notice of Privacy Practices ("HIPPA Privacy Notice") provides more detailed information about how Greenwich Wellness associates uses and discloses PHI. You have the legal right to a copy of our current HIPAA Privacy Notice before you sign this form or at any other time that you request one".

This is to acknowledge my receipt of **Dr. Adam Massoud's** *Notice of Privacy Practices* effective April 14, 2003.

Date: _____

Signature of Individual or Personal Representative: _____

Print Individual's Name: _____

Individual's Address: _____

Name of Personal Representative (if applicable): _____

Description of Representative's Authority to Act for the Individual:

_____

_____

greenwich wellness

Financial Responsibility

I am responsible for all charges incurred, for all treatments rendered for all dates of service here forward.

History/Physical Exam	$199.00
Adjustment	$115.00
Massage Therapy	$58.00
Acupuncture	$132.00
Erchonia Laser	$40.00
IASTM	$132.00
Nutritional Consultation	$160.00
Supplements	Prices Vary
Orthotics (First Pair)	$500.00
Orthotics (Second Pair)	$400.00

I understand my financial responsibility at Greenwich Wellness and will adhere to their policies.

Signature:_____ Date:_____

***All transactions at Greenwich Wellness are non-refundable.**

INFORMED CONSENT
Greenwich Wellness
Dr. Adam Massoud

I hereby request and consent to be performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist(s) who now or in the future treat me.

I understand that the methods of treatment may include, buy are no limited to, acupuncture, moxibustion (the therapeutic use of thermal stimulus at acupuncture points), and nutritional counselling.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects including slight pain or discomfort at the side of the needling, bruising, numbness or tingling, burns, weakness, nausea, dizziness, or temporary aggravation of symptoms existing prior to treatment.

Unusual side effects include: spontaneous miscarriage, fainting, infection, organ puncture, or nerve damage.

I will inform my acupuncturist(s) if I become pregnant or am in the process of trying to become pregnant.

“With this knowledge, I voluntarily consent to the above treatments.”

_____
Printed Name

_____
Patient signature (or patient Representative)

_____
Date

11 Maple Avenue
Greenwich, CT 06830
203-637-1111

Greenwich Wellness

Date:

Patient Number:

How did you hear about Greenwich Wellness? _____

Whom may we thank for referring you to Greenwich Wellness? _____

Name: _____ Male: ___Female: ___ Date of Birth:_____

Address: _____City:_____Zipcode:_____

Preferred Phone: _____ Secondary Phone: _____

Email:_____

Relationship Status: _____ Partner's Name_____ Children: _____

What type of exercise do you perform on a daily basis? ___None ___ Moderate ___Heavy

What do your daily work habits include? (e.g. sitting, standing, light labor, heavy labor, computer work)

_____

Do you smoke? ___Yes ___No How much liquor to you consume on a weekly basis?_____

How much coffee or caffeinated beverages do you consume on a daily basis?_____

(For Women) Are you pregnant? ___Yes ___No

Please list all medications you are currently taking: _____

Allergies: _____

Are you currently experiencing any symptoms? ___Yes ___No

If Yes, please explain:

_____

_____

Where specifically is the problem(s) located? _____

Type of Pain: ___Sharp ___Dull ___Throbbing ___Numbness ___Burning ___Aching ___Shooting ___Tingling ___Cramps ___Stiffness ___Swelling ___Other:_____

Rate the severity of your pain on a scale from 1(least pain) to 10(severe pain) ___

Have you been treated by a chiropractor this year? ___Yes ___No

Have you seen a doctor for this condition? ___Yes ___No

Is this condition getting progressively worse? ___Yes ___No

Greenwich Wellness

11 Maple Avenue
Greenwich, CT 06830
203-637-1111

Have you suffered from:

___ Dizziness
___ Heart Trouble
___ Arthritis
___ Asthma
___ Nervousness
___ Digestive Disorders
___ Sinus Trouble
___ Diabetes
___ Headaches
___ Neuritis
___ Neck Pain
___ Backaches

Have you ever been in a car accident? ___Yes ___No

If Yes, please explain any injuries from the accident:

_____
_____
_____

List any surgeries you have had:

_____
_____
_____
_____

What supplements are you currently taking and/or considering?

_____
_____

Do you feel energized or tired more frequently? If more tired, how do you manage your energy levels?

_____
_____

What additional health goals do you have?

_____
_____

DOCTOR'S NOTES ONLY