

Welcome to

# Inner Sanctum Chiropractic



Date Completed: \_\_\_\_\_

## General Patient Information

Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Profession: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## Primary Complaint

What has brought you in today? \_\_\_\_\_

Where is it located? \_\_\_\_\_ Does it radiate anywhere? \_\_\_\_\_

How long has it been going on for? \_\_\_\_\_

When did it start? \_\_\_\_\_

What were you doing when you noticed it began causing problems? \_\_\_\_\_

On a scale of 1-10, 10 being worst imaginable pain, where do you rank this pain? \_\_\_\_\_

Do you have any numbness, tingling, or sharp shooting pains? \_\_\_\_\_

Has anything made it better? (heat, ice, mediation, rest, positions, etc)  
\_\_\_\_\_

Has anything made it worse? (activity, positions, rest, etc)  
\_\_\_\_\_

What are your treatment goals?  
\_\_\_\_\_  
\_\_\_\_\_

## Personal Health History

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Type (if known): \_\_\_\_\_

Are you taking any medications or supplements? Please list  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any known allergies (including food, medication, and seasonal)?

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Have you had any major traumas/accidents/injuries?

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Have you had any surgeries?

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Major Diagnoses or symptoms? Please Circle Answers (lines below for more room)

Acne	Fainting	Numbness, tingling, weakness
Addiction	Fibrocystic Breasts	Ovarian cysts
ADD/ADHD	Fibromyalgia	Pain with urination
Anemia	Fractures or Broken Bones	Parasitic Infection
Appendicitis	Gallbladder problems	Pneumonia
Arthritis (OA or RA)	Heart Disease	Polycystic Ovarian Syndrome
Autoimmune Conditions	Hepatitis	Sciatica
Bloating	Herpes Simplex, Fever Blister, Cold Sores	Scoliosis
Bruising	High Blood Pressure	Seizures/ Epilepsy
Cancer (specify)	High Cholesterol	Shoulder/ Arm/ Hand pain
Chest pain	Hysterectomy	Stomach Pain
Chronic bronchitis or recurrent lung conditions	Insomnia	Surgeries (List Below)
Chronic Fatigue or Pain	Kidney Problems	Thyroid Problems
Chronic headaches	Lower Limb (leg) pain	Traumas, accidents
Cold hands or feet	Liver Problems	Ulcers
Colitis	Loss of Balance	Vertigo
Constipation	Low Back Pain	Vision Changes
Diabetes (Type, insulin dependent?)	Menstrual Disorder	Weight Gain/ Loss (unintentional)
Difficult Breathing	Mid Back Pain	
Ear Infection	Mood Swings, Depression, Anxiety	
Eating Disorder	Muscle Spasms	
Endometriosis	Nausea/ Dizziness	

Do you have any children? If so, how many and how old are they?

**Females only:**

Age at onset of first cycle? \_\_\_\_\_ Last menstrual cycle? \_\_\_\_\_

Are you taking hormonal birth control? (if so, what kind and how long have you been taking it)

Are you pregnant? \_\_\_\_\_ Number of past pregnancies? \_\_\_\_\_

Have all pregnancies been carried to term? \_\_\_\_\_

How were they delivered? (vaginal or C-section) \_\_\_\_\_

**Lifestyle:**

How often do you consume the following? Please Circle Answers

Soda/ coke	Daily	Weekly	Monthly	Never
White flour/Bread	Daily	Weekly	Monthly	Never
Fried Foods	Daily	Weekly	Monthly	Never
Coffee	Daily	Weekly	Monthly	Never
Packaged Foods	Daily	Weekly	Monthly	Never
Sweets	Daily	Weekly	Monthly	Never
Beer/wine	Daily	Weekly	Monthly	Never
Alcohol	Daily	Weekly	Monthly	Never
Tobacco/smoking	Daily	Weekly	Monthly	Never
Vaping	Daily	Weekly	Monthly	Never

Are you vegetarian/vegan? \_\_\_\_\_

Do you have any food allergies? \_\_\_\_\_

How often do you exercise and what types? \_\_\_\_\_

How active is your job?  Very Active  Somewhat Active  Mostly Sitting

How many hours of sleep do you get per night? \_\_\_\_\_

Do you wake up during the night? \_\_\_\_\_

Do you have difficulty falling asleep? \_\_\_\_\_

Do you feel well rested upon waking? \_\_\_\_\_

## Family Health History

	Mom	Dad	Siblings	Children	Mom's Parents	Dad's Parents
Autoimmune Conditions						
Cancer						
Diabetes						
Epilepsy						
Heart Conditions						
Hormonal Conditions						
Kidney Conditions						
Liver Conditions						
Mental Health Conditions						
Neurological Conditions						
Stomach Conditions						
Thyroid Conditions						
Other						

Please use the lines below for any explanations or additional conditions we missed.

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## Working with Us

How did you hear about us? \_\_\_\_\_

What are your expectations for Dr. Luster as your healthcare provider?

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What are your long-term goals for working with us?

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Do you have a Primary Healthcare Provider? Please list here.

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Have you seen anyone else about these concerns? If so, whom?

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Have you received chiropractic care before?

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What healthy activities do you engage in regularly?

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What self-destructive activities do you engage in regularly?

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What 3 things do you love to do most?

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If there is any additional information you feel we need to know, please write it here.

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In an emergency, who should we contact? Please include name and phone number.

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**Informed Consent for Chiropractic Care**

Chiropractic care, like all forms of health care, may provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: Sprain/Strain injuries, irritation of a disc condition, and rarely fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instance in one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to a stroke.

Prior to receiving chiropractic care in this office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health, your spinal health, and the appropriateness of chiropractic care. These procedures will assist us in determining if chiropractic care is needed or if further evaluations or testing is needed. In addition, they will help us determine if there is any reason to modify your care and/or provide you with a referral to another healthcare provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the doctor deems necessary and to the chiropractic care (to include spinal adjustments) following my assessment.

Print Name Here \_\_\_\_\_

Sign Name Here \_\_\_\_\_ Date \_\_\_\_\_

***If This Health information is for a minor/ child, please fill out and sign below.***

**Written Consent for a Child**

Name of Practice Member who is a Child \_\_\_\_\_

I Authorize Dr. Taylor Luster and any/all Inner Sanctum Chiropractic Staff to perform Diagnostic procedures, evaluation, and rendering of chiropractic care (to include spinal adjustments) to my minor/child. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Inner Sanctum Chiropractic.

Guardian's Name \_\_\_\_\_

Guardian Relationship to minor/child \_\_\_\_\_

Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature (office staff) \_\_\_\_\_ Date \_\_\_\_\_



## **Informed Consent for Acupuncture**

Please read this information carefully, and ask your practitioner if there is anything that you do not understand. While acupuncture has proven to be highly effective in correcting conditions and maintaining overall wellbeing, practitioners are required to advise patients that there may be some risks. Although practitioners cannot anticipate all the possible risks and complications that may arise with each individual case, you should be aware that the following side effects can occur. If there are particular risks that apply in your case, your practitioner will discuss these with you.

### **What are the possible side effects of acupuncture?**

- Drowsiness can occur in a small number of patients, and if affected, you are advised not to drive.
- Minor bleeding or bruising can occur from acupuncture.
- In less than 3% of patients, symptoms may become worse before they improve for 1-2 days following treatment. This is usually a good sign. Please advise your acupuncturist if worsening of symptoms continues for more than 2 days.
- Fainting can occur in certain patients, particularly at the first treatment.

Is there anything your practitioner needs to know? Apart from the usual medical details, it is important that you let your practitioner know:

- If you have ever experienced a fit, faint, or other odd detached sensations;
- If you have a pacemaker or any other electrical implants;
- If you are pregnant;
- If you have a bleeding disorder;
- If you are taking anti-coagulants (blood thinners) or any other medication;
- If you have damaged heart valves or have any other particular risk of infection.

### Statement of Consent

I confirm that I have read and understand the above information, and I consent to acupuncture treatments at ISC. I also understand that I can refuse treatment at any time. By voluntarily signing below I show that I have read this consent to treatment, have been told about the risks and benefits of treatments provided by this clinic, and have had an opportunity to ask questions.

Print Name Here \_\_\_\_\_

Sign Name Here \_\_\_\_\_ Date \_\_\_\_\_



## Media Release Form

I, \_\_\_\_\_, grant permission to ***Inner Sanctum Chiropractic***, hereinafter known as the "Media" to use my image (photographs and/or videos) and/or written reviews for use in Media publications including: Social Media Posts, Videos, Email Blasts, Educational Brochures, Newsletters, Handouts, Magazines, General Publications, Website and/or Affiliates.

I hereby waive any right to inspect or approve the finished photographs or electronic matter that may be used in conjunction with them now or in the future, whether that use is known to me or unknown, and I waive any right to royalties or other compensation arising from or related to the use of the image.

Please **initial** the paragraph below which is applicable to your present situation:

\_\_\_\_\_ - I am 20 years of age or older and I am competent to contract in my own name. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

\_\_\_\_\_ - I am the parent or legal guardian of the below named child. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

Name (please print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of parent or legal guardian: \_\_\_\_\_

(if under 20 years of age)

ISC Staff Signature: \_\_\_\_\_

# Email Consent Form



Practice Member Name: \_\_\_\_\_

Email: \_\_\_\_\_

Inner Sanctum Chiropractic will be abbreviated to 'ISC' for the remainder of this document.

## Risk of Using Email

Transmitting Practice Member information by email has a number of risks that Practice Members should consider before using email. These include, but are not limited to, the following risks:

- Email can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- Emails can easily be misaddressed.
- Backup copies of email may exist even after the sender or the recipient has deleted his or her copy.
- Employers and on-line services have a right to inspect email transmitted through their system.
- Email can be intercepted, altered, forwarded or used without authorization.
- Email can be used to introduce viruses into computer systems
- Email can be used as evidence in court.
- Emails may be not secure, including at ISC, and therefore it is possible that the confidentiality of such communications may be breached by a third party.

## Conditions for the Use of Email

ISC cannot guarantee but will use reasonable means to maintain security and confidentiality of email information. ISC is not liable for improper disclosure of confidential information that is not caused by ISC's intentional misconduct. Practice Members must acknowledge and consent to the following conditions:

- **Email is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular Email will be read and responded to within any particular time.**
- Email must be concise. The Practice Member should schedule an appointment if the issue is too complex or sensitive to discuss via email.
- **All pertinent health information will be printed and filed in the Practice Member's medical record.**
- ISC staff may receive and read messages
- ISC will not forward Practice Member identifiable emails outside of ISC healthcare providers without the Practice Member's prior written consent, except as authorized or required by law.
- The Practice Member should not use email for communication regarding sensitive medical information.
- ISC is not liable for breaches of confidentiality caused by Practice Member or any third party.
- It is the Practice Member's responsibility to follow up and/or schedule an appointment.

## Instructions

To communicate by email, the Practice Member shall:

- Avoid use of employer's computer.
- Put the Practice Member's name in the body of the email.
- Key in the topic (e.g., medical question, billing question) in the subject line.
- Inform the provider of changes in his/her email address.
- Acknowledge any email received from the Provider.
- Take precautions to preserve the confidentiality of email.

## Practice Member Acknowledgment and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email between ISC and me, and consent to the conditions and instructions that ISC may impose to communicate with Practice Member by email.

Practice Member Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## **HIPAA** **Patient Privacy Notification**

This notice describes our policy for how medical information about you may be used and disclosed, how you may get access to this information, and how your privacy is being protected.

In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company, with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize.

### **Safeguards in place at our office include:**

- limited access to facilities where information is stored;
- policies and procedures for handling information;
- requirements for third parties to contractually comply with privacy laws; and
- all medical files and records (including email, regular mail, phone messages, and faxes) are kept on permanent file.

### **Types of information that we gather and use:**

In administering your health care, we gather and maintain information that may include non-public personal information:

- about your financial transactions with us (billing transactions);
- from your medical history, treatment notes, test results, and any letters, faxes, emails or phone conversations to/from other health care practitioners;
- from health care providers, insurance companies, Workers Comp and your employer, and other third part administrators (e.g., requests for medical records, claim payment information).

You may update personal information we have collected about you that identifies you.

We value our relationship and respect your right to privacy. If you have questions about our privacy guidelines, please contact us during regular business hours.

Please sign below indicating that you have read our privacy policy.

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

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



## Financial Policy

Thank you for choosing ISC as your health care provider. The following is a statement of our Financial Policy. Please read it carefully and sign acknowledging your understanding and acceptance of these policies.

- All new practice member forms must be complete prior to being seen and **full payment is due at the time of service or as set up by the care plan agreement. We accept cash, checks, and credit cards.**
- The physician fee is \$275.00 for the initial consult. Treatment Plan appointments are \$185 each. Wellness appointments are \$100 each. These numbers vary with care plan enrollment.
- **Please note that we do not accept insurance as payment. We are not in network with any insurance company.** Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. **THIS BILL IS YOUR RESPONSIBILITY.** Please be aware that some, and perhaps all, of the services provided may be “non-covered” services and/or not considered reasonable and necessary under your insurance plan.
- Insurance companies that require additional information create an added burden and expense to our office. Charges for additional information include: Copies: \$0.50 per page, Short insurance form: \$15.00, Long insurance form: \$25.00, Letter of Medical Necessity: \$40.00, or a Narrative \$100-\$250. We will send out the information when the necessary fees are paid.
- **Appointment Cancellation Policy:** Our policy is to charge for missed appointments if the appointment is not cancelled at **least 48 hours** in advance. **The fee for a missed Consult appointment, Treatment plan appointment, or Wellness appointment is \$75.00.** Please see our Cancellation Policy Form.
  - An appointment on Monday must be cancelled by phone and or email on the preceding Friday no later than 6:00 p.m. to avoid being charged for a missed appointment.

We appreciate your understanding the need for this financial policy. Please feel free to ask any questions you may have.

I have read this financial policy and agree to all of its provisions.

Practice Member Signature \_\_\_\_\_ Date \_\_\_\_\_



## **Cancellation Policy**

Our cancellation policy is in order to provide you with the most flexibility in scheduling possible.

**We require a 48-hour notice for scheduled and rescheduled appointments.** We will be reasonable on this, if you will too.

An appointment on Monday must be cancelled by phone and or email on the preceding Friday no later than 6:00 p.m. to avoid being charged for a missed appointment.

**If later than 20 minutes to a scheduled appointment,** it is likely that you will need to be rescheduled and this fee will be applied. If you are not rescheduled, the treatment will be abbreviated to accommodate, and will be at the original appointment's cost.

**Our policy is to charge for missed appointments if the appointment is not cancelled at least 48 hours in advance. The fee for a missed Consult appointment, Treatment plan appointment, or Wellness appointment is \$75.00.**

**The first missed appointment will be waived.** Any additional no call-no shows will result in a \$75 charge to the payment on file.

Multiple cancelled or rescheduled appointments could result in dismissal.

I understand the cancellation policy and agree to the terms listed above.

Practice Member Name \_\_\_\_\_

Practice Member Signature \_\_\_\_\_

Date \_\_\_\_\_

# Refusal of Billing to Insurance and Medicare



This form is an agreement that Medicare and Insurance are not accepted forms of payment.

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

Medicare Number \_\_\_\_\_

Potential Professional services rendered by Dr. Taylor Luster and Inner Sanctum Chiropractic:

- **Consultation/ New Patient \$275**
- **Advanced 1 hr Visit \$275**
- **Standard 40 min Visit \$185**
- **Basic 20 min \$100**
- **Decompression, Rife \$75**
- **Dry Needling/Acupuncture \$60**
- **E-stim, Heat, Vibration \$50**

**These prices are subject to slight variation according to designated care plan.**

**Explanation:** Medicare is not expected to pay for the above listed professional services because the listed doctor is not enrolled in the Medicare system as a provider of services, and therefore payment for all of these services is denied by law.

## **Patient Agreement:**

I desire the professional services (listed above) from this doctor and refuse to allow this doctor and/or their office to submit any bills to Medicare.

I understand that I am unable to bill any insurance company for services rendered as a result of insurance agreements with Medicare. These agreements usually require that Medicare be billed first and as I am refusing billing to Medicare, billing to a secondary insurance company is unlikely to be accepted.

I recognize that I am fully responsible for all professional services rendered to me.

I recognize that I have no right of appeal to Medicare as no billing will be submitted to Medicare.

I understand that I have the right to change my mind and decision at any time, and further agree that if I decide in the future to have professional services rendered to me by this doctor and/or their office billed to Medicare, I will first inform the doctor of my decision in writing.

I understand that written requests requiring Medicare to be billed will serve as immediate withdrawal from care under Dr. Taylor Luster and Inner Sanctum Chiropractic.

I understand that my signature acknowledges that I have read, agree with, and completely understand this document.

I understand that a copy of this document will be given to me, upon signing, for my own records.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_