Welcome to Breath of Life Chiropractic

Our mission at the Breath of Life Chiropractic is to help you achieve all your health goals and needs. Whether your main reason for seeing us to get out of pain, increase your energy, lose weight or simply take your health to the next level, we are here to provide you with the tools and knowledge to help you on your journey to optimal health.

The first step in the process is to establish your current state of health and the overall function of your body. In order for us to assess this and understand the root cause of your symptoms, we will take you through a series of non-invasive examinations on your initial visit. This includes a full case history, nerve and muscle tests, postural analysis, functional movement assessment, bioimpedance analysis, and spinal x-rays

There are a few simple steps for you to follow prior to your examination:

- No alcohol within 24 hours
- No exercise for 4 hours
- Avoid caffeine or food for 4 hours
- Consume 2-4 glasses of water within 2 hours

On the day of your visit, we ask that you wear comfortable clothing you can easily move in. We will take a postural photo of you, so please avoid multiple layers or bulky clothing. Full tights and pantyhose will need to be removed.

At your initial visit, please bring all completed paperwork (10 pages total) and any previous X-ray or MRI reports, or recent blood work with you so we may refer to these during our case history.

Your initial assessment will take between 45-60 minutes. Please allow sufficient time for your appointment. If you have time constraints, contact our front desk prior to your visit.

PLEASE NOTE:
We have a 24-hour cancellation policy where the agreed upon initial exam fee will be charged if prior notice has not been given. If you are running late please contact the front desk at 231-622-8828. Late arrivals do run the risk of requiring a rescheduled appointment.

**Please make sure you fill in ALL areas of this form, so we can better assist you. Thank you!*

BREATH OF LIFE
CHIROPRACTIC WELLNESS CENTER

8 weeks to wellness

Informed Consent

Rest assured that you will be provided the most appropriate and professional healthcare possible. Our most important goal is the constant improvement and maintenance of your health. Before we get started with your examination procedures which will determine if we can help you, we want you to understand what we do and why we are going to do it.

When a person seeks our care and when we accept a patient for such care, it is essential that they are both working towards the same goals. The goal of our office is to allow your body to function at its highest potential, free from interference and stress that causes dysfunction, disease, and eventually symptoms and sickness. Most importantly, you must understand that our care is not a substitute for medical treatment of any kind, in anyway, or for any reason. The medical approach treats symptoms and diagnoses conditions and diseases. Patients usually go to their medical doctors to get rid of whatever symptoms or conditions are bothering them. This is symptom, sickness and disease care and is necessary in emergency situations. Our approach recognizes that you get symptoms for a reason, attempts to find the cause of the symptoms, and addresses the function of the whole body. This is how we define healthcare; focusing on the optimum function of the individual, and this is how we help patients in our office.

We provide various services in our office including Chiropractic care, massage therapy, exercise therapy and nutritional services. The purpose of Chiropractic care is to restore and maintain the integrity of the spine, spinal cord and its nerve roots. Vital nerve pathways are housed within and protected by the bones of the spine called vertebrae. Misalignments of those vertebrae, which interfere with transmission of normal nerve impulses, are called SUBLUXATIONS. Subluxations are the most common cause of nerve system interference (pinched nerve) and cause dysfunction to the tissue and organs that these nerves supply. With appropriate Chiropractic care, these subluxations can be reduced and corrected, which will restore normal nerve function. A properly functioning nerve system is the foundation to good health.

We look forward to a healthy relationship with you and your family.

I, _____, have read the above, and understand it.
Signature
_____ Date

I acknowledge receipt of BOLC's updated Notice of Privacy Practice, effective January 1, 2017, which replaces earlier versions. Copies of the NPP are readily available in the reception area of BOLC for patient review at any time.
Patient/Guardian Signature: _____
_____ Date

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GENERAL INFORMATION

Please fill out the forms *completely* and *accurately* to the best of your ability so we can quickly get you on the road to health.

Today's Date: _____ Social Security Number (SSN): _____-_____-_____

Name: _____
Last First Middle Initial

Street Address: _____ City: _____ State: _____ Zip Code: _____

Email (to enable the doctors to communicate with you): _____

Cell Phone Number: _____ Home Phone Number: _____

Preferred method of communication (select one): Email _____ Text _____ (Carrier's Name: _____)

Gender: Male _____ Female _____ Age: _____ Birthdate: _____

Are you: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____ Partnered for ___ years Minor _____

Preferred Language: _____ Ethnicity (select one): Hispanic or Latino / Not Hispanic or Latino / Decline to Answer

Race (select one): American Indian or Alaskan Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / Decline to Answer

Your Employer or School: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Occupation: _____

Spouse's Name: _____ SSN: _____-_____-_____ Phone: _____

Spouse's Birthdate: _____ Employer: _____

EMERGENCY CONTACT

Name of Emergency Contact: _____

Relationship: _____ Phone: _____

ACCIDENT INFORMATION

Is your condition due to an accident? Yes _____ No _____ Date of Accident: _____

Type of Accident: Auto _____ Work _____ Home _____ Other (please describe) _____

If this condition is due to an accident, we require you to fill out our accident history form

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8 weeks to wellness

INSURANCE INFORMATION

Please complete this section regardless of your referral source (including non-referral external workshops). We are happy to verify your insurance coverage and provide your benefits information to you. We will NEVER bill your insurance without your permission.

Who is responsible for this account? _____ Relationship to patient: _____

Name of Insurance Company: _____ ID#: _____

Subscriber Name: _____ Birthdate: _____

ASSIGNMENT AND RELEASE:

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Breath of Life Chiropractic Wellness Center, P.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize use of my signature on all insurance submissions.

The above-named organization may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of above signature — Relationship to Patient

X-RAY CONSENT

I hereby give my consent to the Breath of Life Chiropractic and its representatives to take X-rays as deemed appropriate by the examining Doctor of Chiropractic. I also declare that to the best of my knowledge, I am not pregnant. I have read and understood all the above information.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of above signature — Relationship to Patient

CLINICAL SUMMARY (a required EMR question)

_____ I choose to decline paper receipt of my clinical summary after every visit. *(These summaries are often blank as a result of the nature and frequency of chiropractic care).*

FINANCIAL RESPONSIBILITY

Dear Patient,

Breath of Life Chiropractic provides its services directly to you, not to your insurance company. You are ultimately liable for your bill. If you are billing your own claims, we will provide you with an itemized bill. However, as a courtesy to you, we will bill your insurance company for services rendered provided that your deductible has been met and you pay your co-payment at the time of service. In the event that we are billing your insurance company and a check is mailed to you, you MUST bring the check into the office within 7 days so that we may properly credit your account.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

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YOUR VISIT

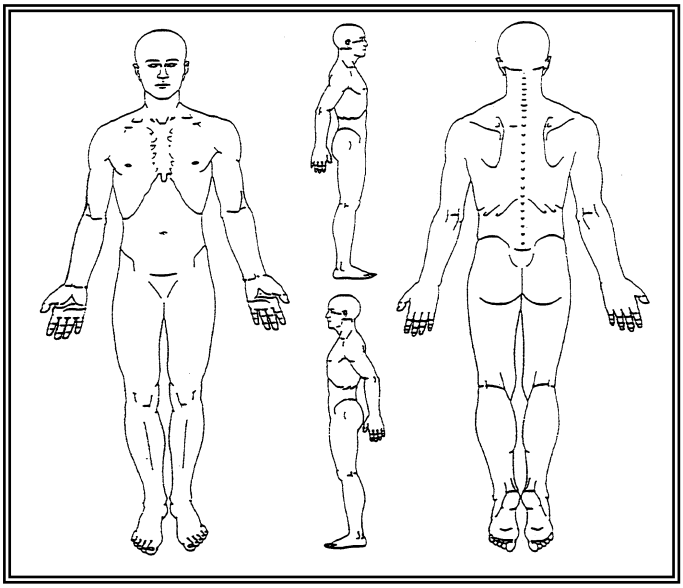
We appreciate you choosing our office. Is there anyone we can thank for referring you? _____

Please indicate the main reason you are seeing us today: _____

_____

If you are seeing us for a pain-related issue, USE THE SYMBOLS on the image to the right to show the type of pain you feel in each location.

X X X X X X X X	DULL / ACHY
/ / / / / / / / / /	SHARP / STABBING
o o o o o o o o o	NUMBNESS / TINGLING
s s s s s s s s s s	STIFF/TIGHT
- - - - - - - - - - - -	BURNING



Using the pain scale to the right, CIRCLE the pain level you experience when your problem is at its very worst.

0 = **No Pain**. No Discomfort
1 = **Minimal Discomfort**. Minor stiffness or tightness.
2 = **Discomfort**. Stiff, tight, sore. Muscle fatigue.
3 = **Minimal Pain**. More than just sore. Uncomfortable.
4 = **Mild Pain**. Noticeable pain but tolerable.
5 = **Moderate Pain**. Aggravating. Still allows movement.
6 = **Strong Pain**. Quite aggravating. Movement slightly limited.
7 = **Very Strong Pain**. Very aggravating. Movement definitely limited.
8 = **Very, Very Strong Pain**. Extremely aggravating. Movement very limite
9 = **Severe Pain**. Brings tears. Almost impossible to move.
10 = **Excruciating Pain**. Agony. Unbearable. Cannot move. ER.

Is there any radiating pain into the arms or legs? Yes _____ No _____ Is there any numbness or tingling? Yes _____ No _____

How often do you experience your problem? (Please indicate for each of the body locations, if applicable)

Constant (75-100% of the time): _____ Frequent (50-75% of the time): _____
Occasional (25-50% of the time): _____ Intermittent (0-25% of the time): _____

List any MDs or Chiropractors you've already seen for this problem: _____

_____

What tests have you already had for this problem? X-rays _____ MRI _____ Myelogram _____ EMG / NCV _____ None _____
Other (please describe) _____

What makes your problem *worse*? Sitting _____ Standing _____ Changing Position _____ Walking _____ Bending _____
Lifting _____ Twisting _____ Reaching _____ Driving _____ Sleeping _____ Sneeze / Cough _____ Computer Work _____
Telephone _____ Going from Sit to Stand _____ Other (please describe) _____

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CHIROPRACTIC WELLNESS CENTER

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MEDICAL HISTORY

Please list any significant conditions you've been diagnosed with or have been treated for over the course of your life: _____

_____

_____

Please list any surgeries you have had over the course of your life: _____

_____

Are you allergic to any medications? Yes _____ No _____ If yes, please list: _____

List any medications, herbs or supplements you are taking and the reason for their use: _____

_____

_____

_____

FAMILY HISTORY

Mother: Living _____ Deceased _____ List any medical problems: _____

Father: Living _____ Deceased _____ List any medical problems: _____

List any problems common to your family: Cancer _____ Diabetes _____ Heart disease _____ High blood pressure _____ Stroke _____ Arthritis _____ Scoliosis _____ Thyroid disease _____ Osteoporosis _____ Other (describe) _____

SOCIAL HISTORY

Are you: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____ Partnered for _____ years

Do you have any children? Yes _____ No _____ If yes, how many? _____

Do you drink alcohol? Yes _____ No _____ If yes, how much and how often? _____

Do you smoke? Yes _____ No _____ If yes, how much, how often and how long? _____

Are you currently employed? Yes _____ No _____

Who is your current employer? _____ How long have you been at this job? _____

What do you do most of the day in your job (postures, positions, and repetitive movements)? _____

_____

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On a scale of -10 to +10 (-10 = Awful, 0 = OK, and +10 =Optimal) please circle how well you think you are doing with the following

The Illness-Wellness Continuum

	WATER INTAKE	ABILITY TO HANDLE STRESS	QUALITY OF SLEEP	EXERCISE	DIET (including supplements)
+10 OPTIMAL	At Least 1/2 my body Weight in oz, daily, No Exceptions	Extremely adaptable to stress	Optimal sleep	Peak physical health and stamina, 5 Days per week minimum	Very minimal carb intake (bread, sugar, pasta) lots of veggies, plenty of protein, good supplements daily
+8 +6 EXCELLENT	3/4 of body weight	Handle stress well	Excellent sleep	Feel good, strong & flexible. Exercise at least 3 times per week	Excellent diet and supplements, rarely cheat
+4 +2 GOOD	Decent consumption consistently	Up & down stress	Good sleep	Occasional exercise	Better than most, but still cheat 2-3 times a week
0 COMFORT ZONE	50% of body weight in ounces	Average stress	Moderate sleep	Physically active but no sweating exercise (chores, walking, etc)	Eat what is available. Processed food is a staple of the diet. Little to no supplements
-2 -4 FAIR	Dehydrated	Moderate stress	Fair sleep	Some activity, poor stamina, sits alot	Fast/junk/sugary food is common, but not every day
-6 POOR	Hardly any water	Extremely stressed	Poor sleep	Mostly sedentary, almost no activity	Don't really think about what I'm eating. Eat what sounds good.
-8 -10 AWFUL	Never Drink Water, Only coffee, pop, energy drinks, etc	Can't cope	Severe insomnia	Sedentary at work, home, and recreation. No activity to speak of	Diet is out of control especially sugar and carbs, but don't know what to do

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8WW 8 weeks to wellness

REVIEW OF SYSTEMS

Please use the scale below (0 to 4) to rate each of the symptoms on this page according to your health status over **the past 30 days**:

0 = Never have this symptom
1 = Rarely have this symptom, effect not severe
2 = Occasionally have this symptom, effect is not severe
3 = Frequently have this symptom, effect not severe
4 = Frequently have this symptom, effect is severe

Head: _____ Headaches _____ Faintness _____ Dizziness _____ Insomnia	**Energy / Activity:** _____ Fatigue / Sluggishness _____ Apathy / Lethargy _____ Hyperactivity _____ Restlessness	**Lungs:** _____ Chest Congestion _____ Asthma, Bronchitis _____ Shortness of Breath _____ Difficulty Breathing
Eyes: _____ Watery or Itchy Eyes _____ Swollen, Red or Sticky Eyelids _____ Bags or Dark Circles Under Eyes _____ Blurred or Tunnel Vision (not including near or far sightedness)	**Weight:** _____ Binge Eating / Drinking _____ Craving Certain Foods _____ Excessive Weight _____ Compulsive Eating _____ Water Retention _____ Underweight	**Heart:** _____ Irregular or Skipped Heartbeat _____ Rapid or Pounding Heartbeat _____ Chest Pain
Ears: _____ Itchy Ears _____ Earaches, Ear Infections _____ Drainage from Ear _____ Ringing in Ears, Hearing Loss	**Emotions:** _____ Mood Swings _____ Anxiety / Fear / Nervousness _____ Anger / Irritability / Aggressiveness _____ Depression	**Digestive Tract:** _____ Nausea, Vomiting _____ Diarrhea _____ Constipation _____ Bloated Feeling _____ Belching, Passing Gas _____ Heartburn _____ Intestinal / Stomach Pain
Nose: _____ Stuffy Nose _____ Sinus Problems _____ Hay Fever _____ Sneezing Attacks _____ Excessive Mucus Formation	**Mind:** _____ Poor Memory _____ Confusion, Poor Comprehension _____ Poor Concentration _____ Poor Physical Condition _____ Difficulty Making Decisions _____ Stuttering or Stammering _____ Slurred Speech	**Mouth and Throat:** _____ Chronic Coughing _____ Frequent Need to Clear Throat _____ Sore Throat, Hoarseness _____ Swollen or Discolored Tongue _____ Canker Sores
Skin: _____ Acne _____ Hives, Rashes, Dry Skin _____ Hair Loss _____ Flushing, Hot Flashes _____ Excessive Sweating	**Joints / Muscles:** _____ Pain or Aches in Joints _____ Arthritis _____ Stiffness or Limited Movement _____ Pain or Aches in Muscles _____ Weakness or Fatigued Muscles	**Other:** _____ Frequent Illness _____ Frequent or Urgent Urination _____ Genital Itch or Discharge

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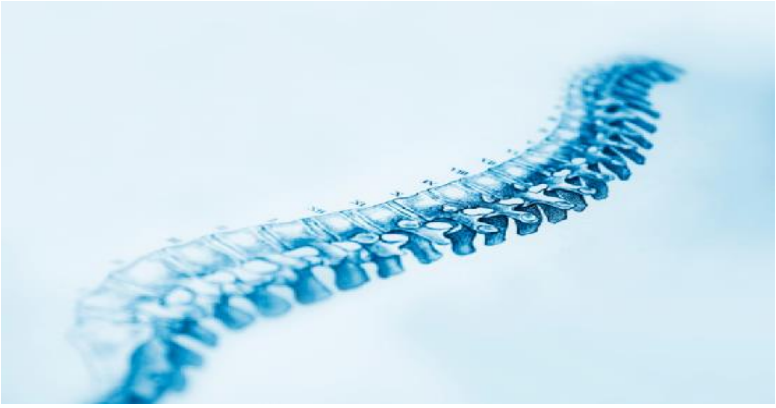
8 weeks to wellness

Give us 8 weeks and we'll change the rest of your life.



PLACE AN "X" BELOW THE BOX IN WHICH BEST DESCRIBES YOUR HEALTH GOALS

PLATINUM	GOLD	SILVER
8 WEEKS TO WELLNESS As a Wellness patient, I want the ULTIMATE opportunity to be well. My goals are to have a healthy nervous system that is free of interference and pain. I want to lose weight and gain energy by doing in-office workouts and massages. Plus, I want to know how to stay chemically healthy by learning how to eat right and still enjoy my lifestyle. I want to change my life and have the life I have always wanted. I want 8 WEEKS TO WELLNESS!	**CHIROPRACTIC CARE** (Slight interest in Wellness) As a patient, your first concern is to address the health of your nervous system through chiropractic and once your nervous system is healthier; your next desire is to look at ways to achieve the ultimate healthy lifestyle through 8 Weeks to Wellness and its components.	**STANDARD** As a chiropractic patient, you will experience life through a new healthy nervous system. Your **GOALS** are to go through three phases of care to a healthier nervous system by eliminating your body's malfunction, correcting the subluxations that exist in your spine, and maintaining them through full spectrum chiropractic.

BREATH OF LIFE
CHIROPRACTIC WELLNESS CENTER

8 weeks to wellness

Notice of Privacy Practices (NPP)

This notice describes how your health information may be used and disclosed by Breath of Life Chiropractic. It also explains how you can access this information yourself. This notice is effective January 1, 2017 and replaces earlier versions

Breath of Life Chiropractic Wellness Center
301 W. Mitchell St Petoskey, MI 49770
231-622-8828 www.breathoflifechiropractic.net

At Breath of Life Chiropractic, we want you to understand our policies and procedures which we have developed to make sure your health information is protected. Our office and employees are subject to State and Federal laws regarding the confidentiality of your health information. We will use and communicate your health information only for the purposes of providing first rate treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and received your written permission, which will be in effect for 12 months if signed without an end date. You may revoke that authorization at any time by submitting a notice in writing.

HOW YOUR HEALTH INFORMATION MAY BE USED:

To Provide Treatment

We will use your health information within our office to provide you with the best health care possible. This may include review and access by our Doctors, assistants, trainers, administrative staff or other personnel providing you treatment in our practice.

To Obtain Payment

We may use your health information when completing invoices to collect payment on treatment you have received in our practice. We may also do this with regards to filling out insurance forms, both paper and electronically. We assure you that we will only work with companies that follow State and Federal HIPAA regulations.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff as some of our best teaching opportunities grow from experiences patients have while receiving care in our practice. As a result, patient health information may be used in training programs for interns, associates, administrative and clinical staff. It is also possible that in the event of an audit by insurance companies or government appointed agencies, your health information may be accessed as part of their quality assurance and compliance review. We will never share your information for marketing purposes.

Abuse or Neglect

We will notify government authorities if we believe a patient is the victim or perpetrator of abuse, neglect or domestic violence. We will make the disclosure only when we are compelled by our ethical judgement, when authorized by the law or with the patient's agreement.

For Law Enforcement

As permitted or required by Local, State or Federal law, we may disclose your health information to a law enforcement official for certain purposes, including if you are the victim of a crime or in order to report a crime.

Public Health and National Security

We may be required to disclose to Federal officials or Military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important to the government if they believe it can lead to the control or prevention of an epidemic.

Family, Friends and Caregivers
We may share your health information with those you tell us assist you in your health, daily care, transportation or finances. We will ask you for your permission to do so first. In the case of an emergency where you are unable to tell us what you want we will use our very best judgement when sharing your health information only when important to those participating in providing you care.

Medical Research
Your health information may be important to furthering research and the development of new knowledge and treatment. Formal review and study of health histories as a part of a research study will happen only under the ethical guidance and approval by an Institutional Review Board. In these cases, your information will be stripped of personal identifiers (ex. Name, DOB)

Patient Reminders
Because we believe that following a care plan is very important to your overall well-being, we will remind you of a scheduled appointment or contact you to arrange an appointment. Additionally, we may contact you to follow up on your care plan or inform you of treatment options that could improve your wellness. These communications are an important part of our philosophy of partnering with our patients to be sure they are receiving the best care we can provide. They may include postcards, letters, phone, text or email reminders. You are welcome to opt out of these communications.

PATIENT RIGHTS
Inspect and Copy Your Health Information-
You have the right to read, review and receive copies of your health care information, including x-rays, complete chart of accounts and billing records. If you would like a copy of your health information, please let us know in writing. We may charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information
You have the right to ask us to update or modify your records if you believe that your health information is incorrect or incomplete. In order to modify your records, you must submit a written request accompanied by your reason for requesting the changes. Please note that we can only modify records created in our practice. We reserve the right to deny a request, in which case you will receive in writing, our reasons for denial within 60 days of your original request.

Documentation of Health Information
You have the right to ask us for a description of how your health information was used by our office for any other reasons than treatment, payment or health insurance reasons. Please let us know in writing if you would like this information and we may charge a reasonable fee for this request.

Request a Copy of this Notice
You have the right to obtain a copy of this original Notice of Privacy Practice directly from our office at any time. Paper copies are available in the waiting room or from any staff member. We can also email you a copy upon request, or you can print it out from our website. We are required to practice the policies and procedures described in this NPP but we reserve the right to change the terms of our Notice. If we change our privacy practices we will supply the revised Notice to our active patients.

YOU HAVE THE RIGHT to express complaints to our HIPAA Security officer, Kyle Denholm, D. C. 231-622-8828, breatholifechiropractic@gmail.com. You may also contact The U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, S.W. Washington, D.C. 20201, calling 1-877-696-3775 or visiting www.hhs.gov

BOLC, all of our officers, agents and employees have reviewed, understand and will adhere to this policy. There will be no tolerance of any violations of this NPP. Violation of this policy is grounds for disciplinary actions, up to and including termination of employment and criminal or professional sanctions.