7921 Tanner Williams Road, Ste B
Mobile, AL 36608
Phone 251.607.0040
Fax 251.607.7202

New Patient Action Plan

1. Your first appointment today will consist of **posture images, examination, insight scan, and x-rays** as the doctor finds necessary. X-rays will then be marked and reviewed by the doctor to review results with you at your second appointment (typically 24 hours turnaround).
2. Your second appointment the doctor will review what he found on your x-rays, you will receive your **first adjustment, and if there are any additional tests or x-rays** needed to determine the best course of care, the doctor will order.
3. Your third appointment is the most important visit you will have; the doctor will go through all of your x-rays, findings, and offer **recommendations on course of care**. There is NO cost for this visit.

If you have insurance, we will verify your coverage for chiropractic care. If your insurance does not cover chiropractic care, we offer ChiroHealth USA**; a medical discount program that saves you 35% off your chiropractic care plus capped family fees for first appointments.

The cost of annual membership for ChiroHealth USA is only $49.00 to cover you and your entire family for one year.
[1]

First Visits:
First family member 1st visit cap: $85.00 (normal average is $209)
Second family member: $60.00
Third and subsequent family members: $35.00

ChiroHealth** Second Visit: Adjustment: $32.50** Stress X-ray (usually needed): $29.25** Total: $61.75**
Insurance Second Visit: Adjustment: $50.00 Stress X-ray (usually needed): $45.00 Total: $95.00

Date: ______________________ Time: ______________________

Third Visit: NO COST

Date: ______________________ Time: ______________________

Total Cost: $ ___________________

Signature: ______________________

Witness: ______________________

[1] Office Use Only: DAY 1 ________________________ DAY 2 ___________________________

Whom may we thank for referring you to this office → ______________________________?

PEDIATRIC APPLICATION FOR CARE AT LIBERATION CHIROPRACTIC & WELLNESS, PC

PATIENT DEMOGRAPHICS

Childs Name____ Today's Date _____/______/_______

Date of Birth _____/_____/______ Birth Height: _______ Birth Weight: _______ Current Height: ______

Current Weight: _____ Age: _____ Address____

City ________________________________ State _______ Zip _____________ Phone (Home) ______________________

Mothers Name: _________________________Mother's Mobile _______________________ DOB____/____/____

Fathers name: _________________________Father's Mobile________________________ DOB ____/____/____

Pediatrician/Family MD ____City & State_______________________

Last Visit: ____/_____/______ Reason for visit:____

Who is responsible for this bill?____

o Father's Social Security # ______-______-_______ o Mother's Social Security # _______-______-_______

Insured's Name:_______________________________ Name of Insurance Company:__________________________

Insured's Date of Birth:__________________________

CHILD'S CURRENT PROBLEM:

Purpose of this visit: _____Wellness Check-up _____Injury or Accident _____Other

Please explain:____

*If your child is experiencing **Pain/Discomfort please identify where and for how long:***

____

1. **When did the** Problem first begin? Date ____/____/______ _____Unknown _____Gradual _____Sudden
2. **Ever had** this problem **before**? No______Yes______ If yes when?_________________________________
3. Any **bowel or bladder** problems since this problem began?: If yes, *(Describe)*:__________________________
____
4. Have you seen any **other doctors** for this problem? No Yes If yes who?________________________________
5. How long ago? ________Days ________ Weeks _________ Months ________Years
6. What were the results of past treatment?____
7. How is this problem **NOW:** ▫ Rapidly Improving ▫ Improving Slowly ▫ About the Same ▫ Rapidly Worsening ▫ Gradually Worsening ▫ On & Off
8. Please list any **medication taken** for this problem:____
9. Please list any **OTHER** medications taken for any other problem:
____
____

10. Has your child ever sustained an injury playing organized sports? (Yes/No)

If Yes; please explain:____

11. Has your child ever sustained an injury in an auto accident? (Yes/No)

If yes, please explain:____

HAS YOUR CHILD EVER SUFFERED FROM: *mark a* **Y for** *YES OR* ***N** N*

☐ Headaches ☐ Orthopedic Problems ☐ Digestive Disorders ☐ Behavioral Problems
☐ Dizziness ☐ Neck Problems ☐ Poor Appetite ☐ ADD/ADHD
☐ Fainting ☐ Arm Problems ☐ Stomach Aches ☐ Ruptures/Hernia
☐ Muscle Pain ☐ Leg Problems ☐ Reflux ☐ Seizures/Convulsions
☐ Heart Trouble ☐ Joint Problems ☐ Constipation ☐ Growing Pains
☐ Chronic Earaches ☐ Backaches ☐ Diarrhea ☐ Allergies to________________________
☐ Sinus Trouble ☐ Poor Posture ☐ Hypertension ☐ Asthma
☐ Scoliosis ☐ Anemia ☐ Colds/Flu ☐ Walking Trouble
☐ Bed Wetting ☐ Colic ☐ Broken Bones ☐ Sleeping Problems
☐ Fall in baby walker ☐ Fall from bed or couch ☐ Fall from crib ☐ Fall off swing
☐ Fall off bicycle ☐ Fall from high chair ☐ Fall off slide ☐ Fall from changing table
☐ Fall down stairs ☐ Fall off monkey bars ☐ Fall off skateboard/skates
☐ Other:

____

I understand that I am directly and fully responsible to Liberation Chiropractic & Wellness, P.C. for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

▫ Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/ former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

______________________________________ ____________________
Parent or Legal Guardian's Signature Date

______________________________________ ____________________
Doctor Signature Date Reviewed

JDD,DC 5/2011

INITIAL NERVE SYSTEM PROFILE

When was your most recent auto accident? ______________________What speed was the collision?______mph

Type of impact: Front / Side / Rear Was treatment received? Please Describe:__________________________

Spinal traumas in the past?

____

INITIAL NUTRITIONAL PROFILE

Are they diabetic, been diagnosed as pre-diabetic or with metabolic syndrome? (Y / N)

Do they eat breakfast daily from Monday to Friday? (Y / N)

How many days per week do they skip one meal? (0) (1) (2) (3) (4+)

How many fast food, refined foods, or pre-pared meals do they eat per week? (0) (1-3) (4-6) (7+)

How many servings of fruit do they have on a given day? (0-1) (2-3) (4+)

How many servings of vegetables do they have on a given day? (0-1) (2-3) (4-5)

Do they regularly drink (1 or more per day) any of the following? (circle all that apply)

Diet Soda Coffee Juice Milk Soda

Please list any supplements taken regularly:

____

____

____

____

____

INITIAL FITNESS PROFILE

How many times per week do they exercise? ___Hours ___Days/Wk

What kind of exercise do they get:

____

What is their ideal weight? __________lbs What is their current weight? ___________lbs

How willing are they to change any of these things to reach their health goals? ***(Scale of 1-10)*** _________

INITIAL TOXICITY PROFILE

Are they regularly exposed to cleaning products or industrial chemicals? (Y / N)

Have you ever noticed mold growing in your home or their school/day care? (Y / N)

Does your home, their school, or car have damp or mildew smell? (Y / N)

Have they received a full standard profile of vaccinations? (Y / N)

Do they receive yearly flu shots? (Y / N)

How many flu shots have they received? _____ (estimate)

Have any members of your family been diagnosed with fibromyalgia,
Chronic fatigue or multiple chemical sensitivities? (Y / N)

Do they have any known symptoms of hormonal system imbalance (thyroid, reproductive, adrenal)? (Y / N)

INITIAL STRESS PROFILE

Do they get an average of 8 hours of sleep per night? (Y / N)

Do they average less than 7 hours of sleep per night? (Y / N)

Are they ever given pills or OTC meds to go to sleep or relax? (Y / N)

Do they have problems focusing or procrastinate on projects? (Y / N)

Do they exhibit feelings of anxiety about completing tasks? (Y / N)

Do they get adequate time with both mother and father on a regular basis? (Y / N)

Doctor Signature ______________________________ **Date Reviewed** ____________________

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Liberation Chiropractic & Wellness PC have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

____ ____/____/____ ☐ *Witness Initials*

Patient or Authorized person's Signature Date

REGARDING: X-rays/Imaging Studies

FEMALES ONLY → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

▫ The first day of my last menstrual cycle was on ____-____-____ Date

▫ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

____ ____/____/____ ☐ *Witness Initials*

Patient or Authorized person's Signature Date

Liberation Chiropractic & Wellness P.C. Notice of Privacy Practice

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders **-we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Danelle Adair at (251) 607-0040. If she is unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

Liberation Chiropractic & Wellness PC's NOTICE REGARDING YOUR RIGHT TO PRIVACY continued….

I have received a copy of Liberation Chiropractic & Wellness PC's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at an time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

____ ______________ ____________
Patient's Name DOB HR#

____ ______________
Patient signature Date

____ ______________
Witness Date

Patient initials: __________-retaining pages 1 of 2

I hereby acknowledge receiving a copy of the practices 'Office Policies' a two page document, the first page of which I have read and retained. This second page is recognized by me as the signature page and will be retained by the practice as evidence of my receiving and understanding this 'Notice'. I further acknowledge that any concerns regarding these 'Policies 'as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.

____ _____________ __ ____________
Patient's Name DOB HR#

____ ______________
Patient signature Date

____ ______________
Witness Date

OFFICE POLICIES

Welcome to Liberation Chiropractic & Wellness PC!

As a potential new patient, we feel it is important that you understand our office policies regarding, how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return. Once you have read "Our Office Policies", if you have any questions or any of these policies are unclear to you, and you would like further explanation before submitting your ***Application for Care*,** please let our front desk know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone's best interests to provide potential new patients as much information as possible about how the doctors at this office practice chiropractic so that an informed decision can be made as to whether they wish to become a patient.

Over time, individuals who are accepted, as patients at this office, gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open bay area, patients have a unique opportunity to observe firsthand the positive results that are achieved and the benefits derived from being under chiropractic care. This knowledge and awareness reaps a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about.

▫ **PATIENT PRIVACY -** Since the majority of patient care takes place in an open bay area it is important to understand that any conversations you have with the doctor can be overheard by other patients. In order to maintain patient privacy it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter you wish to discuss please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.

▫ **YOUR CARE -** When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at Liberation Chiropractic & Wellness PC is rendered primarily to minimize and reduce subluxations, which are a major interference to the expression of the body's innate wisdom. The doctors use 1) Dr. Bucknell Corrective Technique OR 2) a myriad of techniques to accomplish this goal, including but not limited to CLEAR, Pettibon, Arthrostim, Diversified, SOT, ART, and CBP. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through two distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving you overall health.

▫ **FIRST THINGS FIRST-** Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do in addition to being adjusted to maintain their health for a lifetime.

▫ **PATIENT'S REPORT OF FINDINGS** – To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your first adjustment, you will be scheduled for a 'Doctors Report of Findings'. The information you receive at this appointment will be both informative and clinically relevant to your case, therefore attendance is required for individuals who wish to become new patients of this practice. Because the results of your x-rays and all examinations as well as the doctors' recommendations for care, will be discussed at that time, we strongly urge new patients to invite their spouse or significant other to attend. We know from experience that when a patient's family understands the goals and objectives of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options.

FINANCIAL AGREEMENT OF UNDERSTANDING

I would like to become a patient of Liberation Chiropractic & Wellness and participate in the Billing Simplification program offered by this practice to facilitate effortless payment for a certain portion of the cost of services and procedures I have consented to receive over the course of my treatment.

☐ INSURANCE PATIENTS

I have been made aware that most insurance plans impose either a visit or dollar limit and/or restrict chiropractic management approaches by covering only a limited number of treatment types and/or techniques, some of which may be used to treat my condition(s) throughout the clinical course of my care. Further, it has been made clear to me that these limitations are not a consideration in formulating care plans, and that the doctor's recommendations are based solely on achieving my personal goals. With this understood and the realization that full insurance reimbursement is unlikely, I agree to follow the doctor's recommendations for care irrespective of my health plan coverage.

In as much as the doctor has discussed the terms of this 'Agreement of Understanding' and I have conveyed my complete understanding of all payment options available to me, I prefer the office to bill my insurance company and await direct provider reimbursement for all covered services. For this consideration, I will provide any and all assistance, including assigning my benefits, in order to ensure proper reimbursement is made directly to Dr. Michael Bucknell as expeditiously as possible. I further understand that charges for all services have been reviewed with me in advance and those that my insurance does not cover are my responsibility. I further waive any requirement moving forward to sign a "Non-Covered Services Statement" every visit.

☐ CASH PATIENTS

I would like to participate in the payment simplification program offered at this office. Payment options will be provided along with care plan recommendations.

If for any reason I decide to discontinue my care plan, any unused amount I have prepaid will be refunded to me within 30 days of the practice receiving a written statement from me explaining the reasons for my decision.

I understand that my care plan has been designed to stabilize and correct the spine in order to reduce pressure from the nervous system. This is done per the exam and x-ray findings and our clinical experience with the goal of improving overall structure and function. In addition, I understand that my schedule for care may be increased or decreased by the doctor at any time in order to accomplish this goal. It is further understood that if there are any additional costs associated with a change in my care plan, they will be discussed with me prior to my receiving any additional services.

It has been explained to me and I acknowledge that the care plan I wish to participate in imposes two 'situational restrictions' which could cause my care to be suspended or terminated should either one occur. Both have been explained to me and I understand and agree to immediately notify this practice should the following circumstances arise:

In the event I sustain a new injury or have an accident, I realize that I may experience new symptoms and/or a new problem may arise which could impede recovery from my current condition. In such an instance, I recognize that it is important to evaluate any new symptoms to determine how they may affect my current and future health status and assess whether there is a need to modify my current care plan. Once my new symptoms and condition are diagnosed and/or resolved, my care plan will resume.

In the event I decide to interrupt any payment due this office, either because I wish to discontinue my care or for any other reason, I may not resume care without an additional evaluation from my doctor. If I am making monthly payments at that time, it is possible that I will owe money since more services are being rendered in the beginning of my care than the monthly fee covers.

______________________________ ____________
(Patient's Signature) (Date)

______________________________ ____________
(Witness) (Date)