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

Lipo Laser Weight Loss Action Plan

1. Your first appointment today will consist of **a consultation with** a doctor. This will be followed by your first 15 minute Lipo Laser session, followed by 10 minutes of intense vibration therapy.

2. It is recommended that subsequent treatments be scheduled at least twice a week so released fat is not reassimilated.

3. Your results will be increased through proper dietary changes, intense exercise following and in between treatments, cellular detoxification, and improved neurological function and metabolism. If you feel you were not explained these things in enough detail by the doctor, please feel free to ask for further explanation.

For further Lipo Laser package purchases we offer ChiroHealth USA**; a medical discount program that saves you 35% off services in our office plus capped family fees for Chiropractic Exams and X-rays for your whole family. The cost of annual membership for ChiroHealth USA is only $49.00 to cover you and your entire family for one year.

ChiroHealth USA rates:
Lipo Laser sessions only $22.75 (normal fee $35). For example: A package of 6 sessions is only $136.50 (normal fee $210) for a savings of $73.50 which pays your CHUSA membership.

First family member 1st Chiropractic 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: $29.25**	Total: $61.75**
Insurance Second Visit:	Adjustment: $50.00	Stress X-ray: $45.00	Total: $95.00

Date: ___________________________________ Time: ___________________________________

Third Visit: NO COST review of X-rays and Care Plan recommendations

Date: ___________________________________ Time: ___________________________________

Total Cost: $ ___________________

Client Signature: ____ Date: __________________

Technician Signature: ____Date: __________________

Whom may we thank for referring you to this office→________________________________ TODAY'S DATE:________________

WEIGHT LOSS PROGRAM APPLICATION AT LIBERATION CHIROPRACTIC & WELLNESS, P.C.

PATIENT DEMOGRAPHICS

Name: ____Birth Date: _____-_____-_____ Age: _______ ☐ Male ☐ Female

Address: _______________________________ City: __________________________________ State: _____ Zip: ______________

E-mail Address: _______________________________ Home Phone: ____________________Mobile Phone:____________________

Marital Status: ☐ Single ☐ Married Do you have Insurance: ☐ Yes ☐ No Work Phone:_____________________

Social Security #: ____________________________________Driver's License #: ____

Employer: ____Occupation: ____

Spouse's Name _____________________________________Spouse's Employer ____

Insured's Name:_______________________ Name of Insurance Company:_____________ Insured's Date of Birth:____________

Number of children and Ages: ____

Name & Number of Emergency Contact: ___________________________________Relationship: ____________________________

TARGET AREA FOR TREATMENT

Which area(s) of your body are you interested in treating for fat reduction?
☐ Chin ☐ Arms ☐ Abdomen ☐ Love Handles ☐ Back ☐ Thighs ☐ Hips

Which area(s) are you interested in treating for the appearance of cellulite?
☐ Chin ☐ Arms ☐ Abdomen ☐ Love Handles ☐ Back ☐ Thighs ☐ Hips

Current Weight: _____________ lbs Goal Weight: _____________lbs

Current Dress/Pant Size: _____________ Goal Dress/Pants Size: _____________

When was the last time you were at your ideal weight/dress/pants size? ____

Check all that describe your current condition:

☐ Pregnant ☐ Breastfeeding ☐ Cancer ☐ Cancer Remission ☐ Epilepsy ☐ Photosensitivity

☐ Liver Problems (specify) ______________________________Are you under the care of a Physician?____________________

☐ Diabetes (check those that apply) ☐ Type I ☐ Type II Insulin Required ☐ Blood Sugar Monitored ☐ on Meds

☐ Pacemaker ☐ Have had a cardiovascular event (specify) ____

☐ High Blood Pressure ☐ Irritable Bowel ☐ Colitis ☐ Diarrhea ☐ Diverticulitis ☐ Crohn's Disease

☐ Constipation ☐ Acid Reflux ☐ Gastric Ulcer ☐ Heartburn ☐ Thyroid Dysfunction

Please List ALL medications you are taking (both Prescription and Over the Counter): ___________________________________

____

____

____

What exactly is your goal? ____

____

Why is that your goal, and why is it an issue? (physical concern, depression, vanity?) ______________________

____

What steps are you taking to get there? ____

____

What are you willing to do to achieve your goal? ____

____

Have you identified any Fat Storing Triggers? ____

____

Have you ever Detoxified before, and if so what was used and what was the result? ______________________

____

Do you currently exercise, what type, and how often? ____

____

Please answer the following carefully. Only answer what you WILL do for 3 or more weeks, not what you “want” to do, or “know you should” do.

1. Will you drink half your body weight in ounces of filtered water (reverse osmosis, carbon filtered, spring, etc, but NOT tap water)?
    A. Every day, and only water
    B. Every day, but with some other beverages
    C. I will drink more, but not half my body weight in ounces
    D. I will not drink much water most days

2. Will you not eat for 1 Hour before and 2 Hours after Lipo Laser treatments (helps burn the fat released as energy)?
    A. Will do before and after every session
    B. Will do most sessions, but not all
    C. Will do after some sessions, but mostly not
    D. I’m going to eat whenever I want for the most part

3. How much activity are you willing to do (helps burn some of the extra fat being released for energy)?
    A. I will burn 500+ calories with additional intense exercise 5 days a week
    B. I will burn 500+ calories with additional intense exercise only on days I do a Lipo Laser treatment
    C. I will do some form of mild to moderate exercise only on days I do a Lipo Laser treatment
    D. I probably won’t be doing any strenuous exercise

4. Will you follow a detoxification program?
    A. I will do it faithfully, every day, without missing any of my protocol
    B. I will remember most days to do it, but might be inconsistent
    C. I am probably not going to do any detox program, or will miss too many days for it to matter

5. How much more willing are you to eat better?
    A. I will eat perfectly in line with the recommended diet with no exceptions
    B. I will eat more in line with the recommended diet, but not completely
    C. I will try to eat better, when it’s convenient for me, and maybe a little smaller portions of the bad stuff
    D. I am going to eat whatever I want

INFORMED CONSENT AND AUTHORIZATION TO TREAT

I, the undersigned client, hereby authorize Liberation Chiropractic & Wellness P.C. appointed staff to administer such treatment as is necessary. I hereby certify that I understand the advantages and possible complications. I also certify that no guarantee or assurance has been made as to the results that may be obtained. Treatment objectives as well as the risks associated with procedures provided at Liberation Chiropractic & Wellness P.C. 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.

Client Signature: ____ Date: ______________

Technician Signature: ____Date: ______________

OFFICE POLICIES

- If late, time will be forfeited as appointments are booked in blocks without overlap
- The therapy amplifies everything you do, therefor keeping the food journal we will know what works with your body and what works against your body
- If a session needs to be cancelled, we need a full 24 hour notice to reschedule it to another time
- Missing or rescheduling sessions will reduce the effectiveness of therapy

Client Signature: ____ Date: ______________

PAYMENT POLICY

I hereby authorize payment to be made directly to Liberation Chiropractic & Wellness, P.C., for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Liberation Chiropractic & Wellness, P.C., for any and all services I receive at this office. If for any reason I decide to discontinue my care plan purchased through Liberation Chiropractic & Wellness P.C. directly, 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.

Client Signature: ____ Date: ______________

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

I have received a copy of Liberation Chiropractic & Wellness, P.C.'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 a 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 at the request of our staff. At this time, I do not have any questions regarding my rights or any of the information I have received, I do not have any concerns regarding these 'Policies ', and all my questions have been answered by a qualified member of the staff to my complete satisfaction.

Client Signature: ______________________________ Date: ______________

Technician Signature: ______________________________ Date: ______________

CLIENT TREATMENT CHART

CLIENT NAME: ____ AREA BEING TREATED: ________________________

DATE	TECH INITIALS	PRE-POST MEASUREMENT	1.5” ABOVE UMBILICUS	UMBILICUS	1.5” BELOW UMBILICUS	WEIGHT IN LBS

COMMENTS