Name: _____ **Date:** _____ /_____ /_____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

DOB: _____ / _____ / _____ **Age:** _____ **Marital Status:** M S D W **# of Children:** _____

Contact Phone #: _____ **Alternate Phone #:** _____

E-mail Address: _____

Circle Status: Disabled · Unemployed · Student · Homemaker · Business Owner · Employed · Retired

Business, Occupation or Major: _____

Place of Employment or School: _____ **Location:** _____

Emergency Contact or Parent/ Guardian: _____

Relation: _____ **Contact #:** _____

Alternate Emergency Contact Information: _____

Primary Doctor:_____ **Location:** _____

Last Medical Visit: _____ /_____ /_____ **Have you ever been to a chiropractor?** YES NO

Do you belong to a gym? YES NO **If Yes, Gym Name & Location**: _____

INSURANCE INFORMATION

INSURANCE CARRIER:_____ **ID NUMBER:** _____

ASSIGNMENT, RELEASE & PROMISE TO PAY

I, (Print Your Name) _____ request that payment of authorized Medicare, Medicaid, Medigap and/or Private Health Insurance (PHI) benefits be made on my behalf to Dr. Anthony Giantinoto and his affiliates, his employees and agents (collectively "The Office"), for any services furnished to me by said provider.

I authorize any holder of medical information and/or records about me to release to the Office, the Centers for Medicare & Medicaid Services, Medigap and/or PHI and its agents, any information needed to determine benefits and/or payment, and/or acquire adequate medical history and/or diagnostics.

In addition, I also acknowledge that I am responsible for any and all payments set forth by my health insurance carrier(s) for services rendered and/or that were agreed upon prior to my treatment.

Signature: _____ Date: _____ / _____ / _____

CONSENT FOR TREATMENT & TERMS OF ACCEPTANCE SECTION

All patients are required to read this entire section prior to signing it. It is important that you understand the information contained in this document. If anything is unclear, please ask questions before you sign.

The Nature of the Chiropractic Adjustment

The primary treatment I utilize as a Doctor 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 evaluation
range of motion testing	orthopedic testing	basic neurological testing
muscle strength testing	postural analysis	radiographic studies
ultrasound	hot/cold therapy	electrical stimulation
mechanical traction	percussive therapy	myofascial release
trigger point pressure	massage	vibration therapy
exercises	stretches & ROM activities	dietary/ lifestyle recommendations

Initials: _____

THE MATERIAL RISKS INHERENT IN A CHIROPRACTIC ADJUSTMENT

As with any healthcare procedure, there are certain complications that 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. I 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 my attention, it is your responsibility to inform me.

Are you currently taking, or have you taken any of the following Fluoroquinolone Antibiotics over the course of the last year? Avelox (moxifloxacin), Cipro (ciprofloxacin), Factive (gemifloxacin), Levaquin (levafloxacin), Noroxin (norfloxacin), Besivance (besifloxacin), Cetraxal, Ciloxan (ciprofloxacin), Iquix, Quixin (levofloxacin), Ocuflox (ofloxacin), Vigamox (moxifloxacin), Zymar (gatifloxacin), Moxeza (moxifloxacin), Cetraxal, Ciprodex (ciprofloxacin), Floxin (ofloxacin), Xtoro (finafloxacin), Quinsair (levofloxacin), Baxdela (delafloxacin)

_____ YES _____ NO

The Probability of Those Risks Occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone. I evaluate for possible weaknesses during the taking of your history, the performance of the examination, and the

evaluation of any available radiographic studies. Stroke has been the subject of tremendous disagreement. The incidences of stroke from chiropractic treatment are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The Availability and Nature of Other Treatment Options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics, topical creams and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and painkillers
- Hospitalization and/or 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 or treating practitioner.

The Risks and Dangers Attendant to Remaining Untreated

Remaining untreated may allow the formation of adhesions and stiffness, 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.

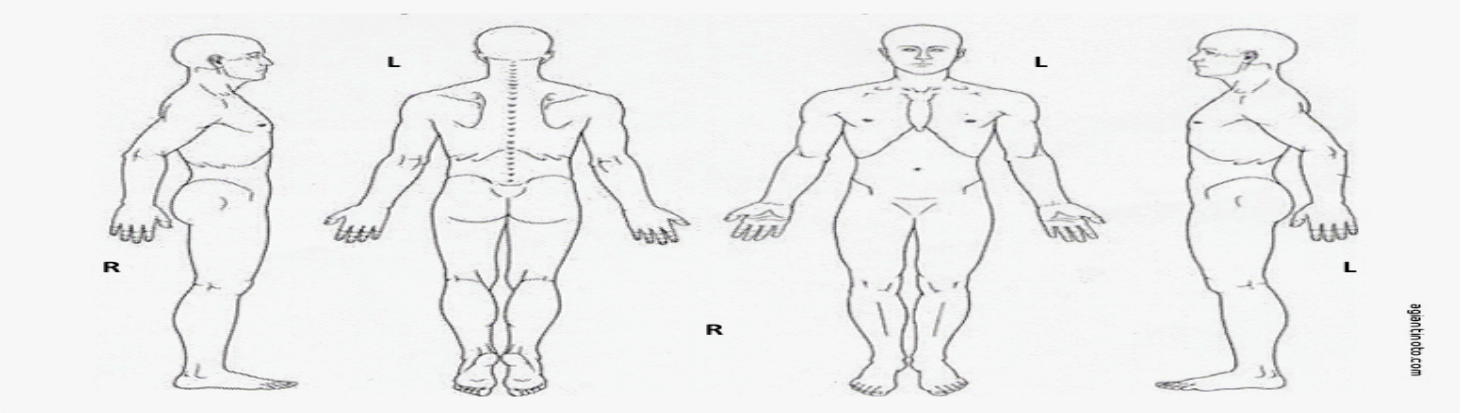
PLEASE DO NOT SIGN THE FOLLOWING SECTION UNTIL YOU HAVE READ, FULLY UNDERSTAND, AND HAVE MET WITH DR. ANTHONY TO DISCUSS THE INFORMATION PRESENTED ABOVE

I have read, or I have had read to me, the above explanation of the chiropractic adjustment, the associated and/or alternate treatment options, and the risks of treatment and no treatment. I have discussed these topics with Dr. Anthony Giantinoto 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.

_____	Anthony Giantinoto, DC
Patient's Name	**Doctor's Name**
_____	_____
Patient's Signature (Parent or Guardian, if a minor)	**Doctor's Signature**
Dated: _____ / _____ / _____	**Dated: _____ / _____ / _____**

Please mark the location of your pain and/or symptom(s) below.



Date symptoms began: _____ Symptoms happened… **gradually or suddenly**

Details of your condition(s): *Use the back of this form, if necessary.*

_____

_____

_____

Have you sought out any other type treatment? No Yes _____

Level of Stress: Low Medium High **Main Source of Stress:** _____

Medical Conditions: None

_____

Prescription Drugs: None

_____

Surgeries: None

_____

History of Cancer: None

_____

Bowel or Bladder Issues: None

_____

Height: ____ft ____in **Weight: _____ lbs.** **Exercise: _____ x per week**

Sleep Per Night: _____ hrs **Daily Water Intake: _____ cups or liters**

Circle: Alcohol Use Tobacco Use Coffee/Tea Antacids Energy Drinks OTC Drugs

Vitamins/Diets: _____

Activities or Hobbies: _____

HIPAA Release of information AUTHORIZATION FORM

I, _____ (Print Name) hereby authorize Dr. Anthony Giantinoto and his affiliates, his employees and agents (collectively "The Office"), to use and/or disclose the protected health information (PHI) described below to any person and/or organization for the purpose of helping me to resolve claims and health benefit coverage issues. Specifically, my complete PHI maintained by "The Office" *(e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number)*. We do not share without your consent the following information: Mental Health Records, Communicable Diseases, Alcohol/ Drug Abuse Treatment and/or OTHER (please specify): _____.

I understand that any personal health information or other information released to any of the persons or organizations identified above may be subject to re-disclosure by such persons/organizations and may no longer be protected by applicable federal and state privacy laws.

This authorization is valid from the date of my, or my representative's, signature below and shall remain in force and effect until (9) months after my death or the following date that we have agreed upon that this authorization expires. **Alternate Authorization Expiration Date:** _____

I understand that I have a right to revoke this authorization by providing written notice to "The Office." However, this authorization may not be revoked if "The Office", it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

Signature: _____ **Date:** _____ / _____ / _____

(If Applicable) **Legal Representative's Signature Section**

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

Name of Legal Representative: _____

Signature: _____ **Date:** _____ / _____ / _____

Name of Witness: _____

Signature: _____ **Date:** _____ / _____ / _____