NUTRITION

Using Nutrition as a form of therapy in healthcare is entirely supportive to the body. It supports and nurtures normal physiological processes. In no way should this form of approach be misconstrued as a form of treating diseases or conditions, or as substituting for traditional medical care. Should symptoms arise which concern you or persist your physician should be consulted.

The muscle testing procedure is a means of finding areas of need in the body, where a lack of vigor exists, which can aid in determining what may be malnourished or impoverished. In no way does this form of testing provide a diagnosis or describe a disease condition. There are no tests for cancer or AIDS for example. Conditions cannot be tested using muscle testing.

Each person is unique and responses to different foods are varied. It is advised that careful attention be given to any abnormal sensations that might ensue following the use of special dietary foods, and that one discontinues immediately the use of anything when reactions occur. There are no chemicals, synthetics, or drugs in any of the Standard Process products, which have both vegetable and animal origins.

Nutrition therapy is a gradual process of nurturing the body and while results should be noticed almost immediately, final results require on average one to four months depending on what area is being supported. Supplements are best taken with food at mealtime, unless otherwise directed, and rarely may bring some nausea or upset, usually gone within a few hours. Some supplements may vary in color from bottle to bottle due to variation in harvest time.

Due to the receding quality of food in these modern days supplementation is one way of increasing the quality of nutrition. In no way can nutrition cure a disease or illness. It is strictly being recommended as a means of supplementing the normal diet and promoting nourishment for all body parts and systems. Our sole purpose in using nutritional supplementation is to support your normal physiological processes.

It is a privilege to assist you in learning more about what you can do to promote health and wellbeing in the field of nutrition.

Total Health Chiropractic and Nutrition Center
Dr. Keith Kimberlin

NOTICE OF UNDERSTANDING AND AGREEMENT:

I hereby, attest to the following:

1. I fully understand that the Nutrition Consultant I am seeing in this office is not consulting for medical, diagnostic, or treatment procedures.

2. The services performed by the Nutrition Consultant are at all times restricted to helping me gain a better understanding of my degree of "health" (not disease), so I will have a greater self-awareness and be able to use a self-care program for daily living.

3. I understand that as a Nutrition Consultant the recommendations, discussion, sale of food, nutrition, nutritional supplements, vitamins or minerals, food grade herbs, or other nutrients as foods for special dietary use only pertains to the whole body concept of nutrition, and does not relate in the context of any specific ailment or condition.

4. The appointments do not involve the diagnosing, prognosticating, treating or prescribing of medicines or the treatment of disease, or any act which will constitute the practice of medicine in this state, for which a license is required.

Signed__________________________ Date____________

Print name________________________

Referred By_______________________

CHIROPRACTIC CASE HISTORY/PATIENT INFORMATION

Date: ______________________

Name: ______________________ Social Security #: ______________ Home Phone: ______________

Address: ______________________ City: ______________ State: ________ Zip: ______________

Email Address: ______________________ Fax#: ______________ Cell Phone: ______________

Age: ________ Date of Birth: ______________ Race: ________ Marital: M S W D

Occupation: ______________________ Employer: ______________________

Employer's Address: ______________________ Office Phone: ______________

Spouse: ______________________ Spouse Occupation: ______________ Employer: ______________

# of Children: ________ Name of nearest relative: ______________________ Phone: ______________

How were you referred to our office? ____

Primary care doctor: ______________________ Doctors you have seen in past year: ______________

____

When doctors work together it benefits you. May we have permission to update your medical doctor regarding your care at this office? YES NO

HISTORY OF PRESENT ILLNESSES

Chief complaint/purpose of this appointment: ____

Date symptoms appeared or accident occurred: ____

Is this due to: Auto Work Other ____

Have you ever had the same or similar condition? YES NO If yes, when and describe: ______________

____

Days lost from work? ______________ Date of last physical examination: ______________________

Have you been treated for this condition by another physician? YES NO If yes, by whom? ______________

Medication & Vitamin List

Vitamin / Medication Name	(non) or Rx Strength	Date began	Date stopped	Prescribed by Dr. or Self

Please list all past surgeries: ____________________

Please list all previous accidents and falls: ____________________

TERMS OF ACCEPTANCE

When a person seeks chiropractic and rehabilitation health care and is accepted for such care, it is essential for both parties to be working towards the same objective. As a Chiropractic & Rehab facility we have one main goal, to detect and correct/reduce the vertebral subluxation complex. It is important that each person understand both the objective and the method that will be used to attain this goal. This will prevent any confusion Or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express it's maximum health potential.

We do not offer to diagnose or treat a disease or condition other than vertebral subluxation. Regardless of what a disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **Our Only Practice Objective** is to eliminate a major interference to the expression of the body's innate wisdom and ability to heal. Our only method is specific adjusting to correct vertebral subluxations combined with rehabilitation procedures.

NOTE: It is understood and agreed the amount paid to Total Health Chiropractic for x-ray, is for examination only and the x-rays will remain the property of this office, being on file where they may be seen at any time while a patient of this office.

CONSENT TO CARE

I do hereby authorize the doctors of Total Health Chiropractic to administer such care that is necessary for my particular case. This care may include consultation, examination, spinal adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays or any other procedure that is advisable, and necessary for my health care.

Furthermore, I authorize and agree to allow the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving ás back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration to allow for normal biomechanical motion and neurological function.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures related to my health care. I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I understand and informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to fractures, disk injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. The doctor will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions treated at this clinic.

I also clearly understand that if I do not follow the Doctors specific recommendations at this clinic that I will not receive the full benefit from the programs offered, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the Doctor for all services rendered. I also understand any sum of money paid under assignment by any insurance company shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the doctor.

I, ____________________, have read or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent, and by signing below I agree to the above-above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

Signature____________________ Date __________ *(If under age 18) Parent's signature*

Total Health Chiropractic and Nutrition Center

Financial Policy

Welcome to our practice. Our office is committed to the overall health and well-being of your family, with a special emphasis on health and wellness. The following is designed to prepare and inform you of our policies regarding payment and insurance.

* The parents and/or legal guardian who brings the patient for their initial visit is responsible for payment independent of what a divorce decree may state. Reimbursement must be made between the divorced parents. We will not intervene.

* Payment in full is due at the time of service. We gladly accept cash, check, ATM/debit cards, Visa and MasterCard.

* Any unpaid balance over 60 days will be assessed a finance charge of 18% A.P.R. Any balances left unpaid over 90 days will be sent to a collection agency or small claims court and will be assessed a collection fee of $65.00 plus any other costs/fees incurred while attempting to collect the debt. All accounts sent to collections will be dismissed from the practice.

* There will be a $30.00 service charge for all insufficient checks that are returned.

* Please call our office immediately if you receive a statement for a balance that is in question.

Authorization:

- I have read and accept the above Financial Policy, understand it and agree to the terms set forth regarding payment.

____
Signature

________________________________ ________________
Print Name Date