Thrive Healing Arts Center L.L.C.

Dr. Janet T. McKush

Chiropractic Physician
1751 Shoreline Boulevard, Prior Lake, MN 55379
952-226-2229 *thrivehealingartscenter.com*

Name:_____ Date:_____
Address:_____
Street City State Zip
Home Phone:_____ Cell Phone:_____
Work Phone:_____ Email:_____
Date of Birth: ____ / ____ / ____ Age: _____ Gender: M / F
Current Marital Status (circle one): single married separated divorced widowed
Name of Significant Other: _____Number of Children:_____
Children's Names / Ages: _____
Employer: _____Employed: FT PT student
Employers Address: _____
Street City State Zip
Job Description: _____ Work Intensity Level: _____

How did you hear about our office? _____

Reasons you are consulting our office: (check all that apply)

- o I have a specific problem / pain and want help with eliminating this problem / pain.
- o I am willing to make lifestyle changes with diet and exercise to facilitate healing.
- o I have no current symptoms. I am here for wellness care and to optimize my health.

Thrive Healing Arts Center LLC is a fee-for-service practice. **Payment is expected at the time of service.** Credit card, check and cash payments are accepted. You should notify the doctor if you are in an auto accident or experience an injury at your place of work. In these instances Dr. McKush will refer you to a qualified provider that will render care and assist you in submitting claims for your injury.

Appointment time is limited, therefore a missed appointment fee will be incurred unless cancellation is made the day prior to your appointment ($50 or $90 depending on appointment length/type).

I understand and agree that health insurance policies are an arrangement between my insurance carrier/s and me. I understand that Dr. McKush will provide me with a statement to submit to my insurance company or HSA, and any reimbursements should be pursued by and paid to me. Should funds be mistakenly paid to Thrive Healing Arts Center LLC, I will be credited or reimbursed.
I understand and agree that all services, supplements, or healing supplies rendered to me at Thrive Healing Arts Center LLC are charged directly to me and that I am personally responsible for payment.

Patient Signature: _____ Date: _____

Thrive Healing Arts Center, L.L.C.

Dr. Janet T. McKush, Chiropractic Physician
952-226-2229 *thrivehealingartscenter.com*

Child's Name (last, first, middle): _____

Mother's Name (last, first, middle): _____

Father's Name (last, first, middle): _____

Address: _____
Street City State Zip

Home phone: _____ Mother's work phone: _____ Father's work phone: _____

Cell Phone: _____ Email: _____

Date of Birth: ____/____/____ Age: _____ Birth Weight: _____ Current Weight: _____

Gender: M F Social Security # _____ Birth Length: _____ Current Length: _____

Number of Siblings: _____

Type of Birth: Normal vaginal Suction Forceps Breech Cesarean
Drug induced Pain medications Prolonged labor Short labor

Location: Home Birthing Center Hospital

Problems during pregnancy: _____

Problems during labor/delivery: _____

APGAR Scores: _____ _____ Was there presence at birth of: Jaundice (yellow) Cyanosis (blue)

Congenital anomalies/defects: _____

Infant feeding: Breast Bottle Formula Other: _____

Number of hours child sleeps per night: _____ Quality of sleep: Good Fair Poor Naps: _____

Obstetrician/Midwife (name, phone number): _____

Pediatrician/Family MD (name, phone number): _____

Date of last visit to MD: _____ Purpose: _____

Immunization History: _____

Purpose of this appointment: _____

Has your child ever been treated on an emergency basis? Yes No

Describe: _____

Authorization for Care of a Minor

I hereby authorize this clinic and it's doctor(s) to administer care as they so deem necessary to my son/daughter/ward.

Signed: _____ Witnessed: _____ Date: _____

I realize that I am responsible for all fees charged by this clinic and that I will pay for all services as they are performed.

X-rays remain the property of this clinic.

Signature: _____ Date: _____

Child's Health History

Pregnancy History: _____

_____

_____

Delivery/Birth History: _____

_____

_____

Accidents or Injuries: _____

_____

Surgeries: _____

Medications: _____

Supplements: _____

Family History of (circle all that apply): Heart Disease Lung Disease Diabetes Cancer Depression

Other: _____

Developmental History, At what age did this child:

Respond to sound: _____ Follow an object with eyes: _____ Hold head up: _____ Sit alone: _____

Crawl: _____ Stand: _____ Walk alone: _____

Childhood Diseases (with approximate age):

Chickenpox _____ Rubella _____ Mumps _____ Measles _____

Whooping Cough _____ Other: _____

Has this child ever suffered from:

Dizziness	Backaches	Heart trouble	Chronic earaches	Diabetes	Tuberculosis
Hypertension	Colds/Flu	Arthritis	Headaches	Asthma	Allergies
Neuritis	Sinus trouble	Constipation	Diarrhea	Anemia	Digestive disorders
Poor appetite	Hyperactivity	Bed wetting	Convulsions	Paralysis	Rheumatic fever
Fainting	Walking problems	Broken bones	Neck problems	Arm problems	Leg problems
Growing pains	Joint problems	Behavioral problems			

Present History:

Does anyone in your house smoke? Yes No

What are this child's favorite foods? _____

What is this child's typical diet? _____

_____

Number of bowel movements per day: _____ Number of urinations per day: _____

Is there anything else I should know? _____

_____

_____

_____

_____

Thrive Healing Arts Center L.L.C.
Patient Consent for Treatment

I hereby request and consent to the performance of chiropractic adjustments and adjunctive procedures, which may include acupuncture and/or Applied Kinesiology testing, and /or nutritional recommendations, on me (or the patient named below, for whom I am legally responsible) by Dr. Janet McKush D.C. with Thrive Healing Arts Center L.L.C.

Chiropractic

I have had the opportunity to discuss with the doctor of chiropractic the nature and purpose of chiropractic adjustments and other procedures. I understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits nor is there guarantee to the outcome of these procedures.

I understand and am 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, disc injuries, strokes, dislocations, and sprains. I do not expect the provider to be able to anticipate and explain all of the risks and complications, and I wish to rely upon the provider to exercise judgment during the course of the procedure which the provider feels at the time, based upon the facts known to her, is in my best interest.

Acupuncture

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Unusual risks with acupuncture are spontaneous miscarriage, nerve damage and organ puncture (including lung puncture or pneumothorax). Infection is another possible risk, although the certified chiropractic acupuncturist Dr. Janet McKush uses sterile disposable needles and safe environment. I understand that while this document describes the major risks of treatment other side effects and risks may occur.

I do not expect the certified chiropractic acupuncturist Dr. Janet McKush to be able to anticipate and explain all risks and complications during treatment, and wish to rely on her to exercise judgment in the course of treatment which she thinks at the time, based on the facts known, is in my best interest. I understand that results are not guaranteed.

Applied Kinesiology

I have requested a chiropractic evaluation, which at Thrive Healing Arts Center L.L.C. utilizes Applied Kinesiology /muscle testing for analysis in conjunction with

other conventional chiropractic testing procedures. I understand that the practice of Applied Kinesiology testing originated in 1964 by Dr. George Goodheart, whose techniques are utilized today by some alternative doctors of medicine, osteopathy, dentistry, psychology and naturopathy, as well as chiropractors, for analysis, treatment, and nutritional recommendations. This procedure is experimental in nature. While there has been peer review research and publications of Applied Kinesiology in professional journals, some of the techniques have not been supported, and results were inconsistent as measured using standard scientific methods.

Dr. Janet McKush with Thrive Healing Arts Center L.L.C. is certified in Applied Kinesiology. I agree to the above testing procedures and to treatment as agreed upon by the doctor and myself. I am willing to take responsibility for and reserve the right to accept or reject any recommendations related to muscle testing.

Nutrition

I understand that according to the federal Food, Drug, and Cosmetic Act, Section 201 (g)(1), the term 'Drug' is defined to mean: "Articles intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease". I understand that a vitamin is not a drug, neither is a mineral, trace element, amino acid, herb, or homeopathic remedy. Although these may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug.

I understand that dietary or nutritional advice is not intended as a primary treatment and/or therapy for any disease or particular bodily symptom. Nutritional counseling, dietary advice, and vitamin recommendations are provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition to support the biochemical processes of the body. Nutritional recommendations may also enhance the stabilization of chiropractic adjustments and treatment.

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

Patient Name (Print):_____Date:_____

Patient Signature:_____Date:_____
(If patient is a minor, signature of parent / guardian)

Provider Signature:_____Date:_____

Patient Health Information Consent Form

We want you to know how your Patient health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you have read and understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI we encourage you to read the HIPAA NOTICE that is available to you at our front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the health insurance company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known in this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations or these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of patient Date