

# Fountain Chiropractic & Wellness Center

## Informed Consent to Treatment

The State of Colorado requires that every patient be informed of the risks of treatment and the alternatives to treatment prior to the beginning of treatment. The following is Fountain Chiropractic's informed consent. We intend this consent form to cover the entire course of treatment for your present, and for any future conditions for which you seek treatment at this office or any other office under the direction of Dr. Jarod K. Waters. The nature of treatment: The doctor will use his/her hands in order to manipulate your joints, muscles, tendons, or ligaments. You may hear a "click or pop" similar to when one "cracks" a knuckle. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound, or traction, as well as exercise instruction may be utilized at this office. There are inherent risks in any and all treatments delivered by any health care provider. This Facility is no exception. Although we take every precaution, there are indeed some slight risks to manipulation. The risk is very minor in any treatment of extremities. The risks involved in treatment of the spine are several, including but not limited to: muscular strain, ligamentous sprain, fractures, and injury to the discs, nerves, or spinal cord. The risks involved in the treatment of the neck include but are not limited to: any of the preceding list, but also include the remote possibility of a cerebral vascular accident leading to death. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary physical therapy procedures can produce skin irritation, burns, or other minor complications.

Other treatment options that could be considered may include the following: Over the counter analgesics. The risks of these medications include irritation to stomach, liver, kidneys, and other side effects in a significant number of cases.

Medical Care: Typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include numerous undesirable effects, usually more serious than those listed above and patient dependence in a significant number of cases.

Surgery in conjunction with medical care: adds the risks of adverse reaction to anesthesia (which includes death) as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and include chronic pain cycles. It is quite probable that delay of treatment will complicate the condition, and make future rehabilitation more difficult. If you have any concerns or questions please contact Dr. Waters who has gone to great lengths to make your health and safety our top priority. We will be glad to explain any concern about treatment or treatment options with you and your family. We will only recommend treatment for you that we would feel comfortable having performed on ourselves.

I have read the above explanation of treatment. I also had the opportunity to ask questions and have them answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment, I have freely decided to undergo treatment, and hereby give my full consent to treatment.

\_\_\_\_\_  
Signature of Patient or Guardian of Patient

\_\_\_\_\_  
Date

# Fountain Chiropractic and Wellness Center

## Our Privacy Practices

In our office, all health information is considered confidential and we are careful about how we use it. This notice describes how your health information may be used and disclosed and how you can get access to this information. We may share your information in order to treat you, collect payment, or referral to another health provider. You have the right to request a copy of your health record.

## We may use your health information in the following ways:

- Health and safety reasons
- Reporting victims of abuse
- Court hearings and filings
- Reporting to workers compensation
- Request a list of whom we share your health information
- Ask us to limit the information we share
- Advise our management if you believe your privacy rights have been violated
- Request confidential communications
- Amend your protected health information

*These privacy practices are effective at the time this form is signed*

## Consultation & Exam

To begin today's visit, we will collect some confidential health information and then sit and speak with you. After we learn more about your condition, we will perform some preliminary screening tests. If we believe that we may be able to help you, we will recommend a complete examination so we can thoroughly evaluate your condition. We will always inform you of associated fees before we perform any procedure or service.

## Report of Findings

Patients who are examined will receive a report of our findings from the recorded history, consultation, and examination. If we believe we can help, we will accept your case at this time. If we believe that you will not respond to our care, we will not accept your case and may refer you to another provider.

## Treatment Plan

If we accept your case, we may recommend treatment options based on your unique needs and then an individualized treatment plan may be created to address your short and/or long-term goals. As you advance through treatment, periodic progress evaluations will measure and compare your improvement.

## Record Release Permission

Please list all the providers/individuals that you would like us to release your information to (we will not release any information to any person not listed).

Name	Contact Info

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Date

# PERSONAL INFORMATION

Please Print Legibly

First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Text Reminders? Y N  
Email \_\_\_\_\_ Social Security # (last 4) \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Marital Status \_\_\_\_\_ Sex \_\_\_\_\_ Number of Children \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Address \_\_\_\_\_ City/Zip \_\_\_\_\_ Telephone \_\_\_\_\_

## EMERGENCY CONTACT

Name \_\_\_\_\_ Telephone \_\_\_\_\_  
Address \_\_\_\_\_ City/Zip \_\_\_\_\_

## FINANCIAL AGREEMENT

I understand that all services are rendered on a cash, check, or credit card basis. Unless other arrangements have been made and approved, I agree to pay for each session at the time of the session. I also agree to the \$20 returned check charge in the event that my check is returned.

***I understand that I am personally responsible for all charges not paid by Insurance.***

Purpose of appointment \_\_\_\_\_  
How did the injury happen \_\_\_\_\_  
\_\_\_\_\_  
Todays condition started on \_\_\_\_\_  
What activities aggravate it \_\_\_\_\_  
Is it worse at certain times \_\_\_\_\_  
Does it interfere with work \_\_\_\_\_ Sleep \_\_\_\_\_  
Is it getting progressively worse? \_\_\_\_\_  
Other doctors seen for this condition \_\_\_\_\_  
Type of treatment \_\_\_\_\_  
Results \_\_\_\_\_

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**Habits**

- Alcohol: Type \_\_\_\_\_
- Amount: \_\_\_\_\_
- Diet: Salt intake \_\_\_\_\_
- Fat intake \_\_\_\_\_
- Sleep: Difficulty falling \_\_\_\_\_
- Continuity disturbances \_\_\_\_\_
- Early morning awakenings \_\_\_\_\_
- Daytime drowsiness \_\_\_\_\_
- Other \_\_\_\_\_
- Smoking: Packs daily \_\_\_\_\_
- Exercise Routine: \_\_\_\_\_
- Caffeine: coffee, cups daily \_\_\_\_\_
- Other \_\_\_\_\_

MEDICATIONS: \_\_\_\_\_  
 DRUG ALLERGIES: \_\_\_\_\_

**Medical History**

- Ringing in Ear \_\_\_\_\_
  - Ear Infections – Frequent \_\_\_\_\_
  - Dizziness/Fainting \_\_\_\_\_
  - Failing Vision \_\_\_\_\_
  - Eye Infections \_\_\_\_\_
  - Nose Bleeds \_\_\_\_\_
  - Sinus Trouble \_\_\_\_\_
  - Sore Throats – Frequent \_\_\_\_\_
  - Hay Fever/Allergies \_\_\_\_\_
  - Pneumonia \_\_\_\_\_
  - Bronchitis/Chronic Cough \_\_\_\_\_
  - Asthma/Weezing \_\_\_\_\_
  - High Blood Pressure \_\_\_\_\_
  - Heart Murmur \_\_\_\_\_
  - Swollen Ankles \_\_\_\_\_
  - Leg Pain – Walking \_\_\_\_\_
  - Varicose Veins/Phlebitis \_\_\_\_\_
  - Loss of Appetite \_\_\_\_\_
  - Difficulty Swallowing \_\_\_\_\_
  - Indigestion or Heartburn \_\_\_\_\_
  - Persistent Nausea/Vomiting \_\_\_\_\_
  - Peptic Ulcers \_\_\_\_\_
  - Abdominal Pain – Chronic \_\_\_\_\_
  - Gall Bladder Trouble \_\_\_\_\_
  - Jaundice/Hepatitis \_\_\_\_\_
  - Change in bowels \_\_\_\_\_
  - Diarrhea/Constipation \_\_\_\_\_
  - Bloody or Tarry Stools \_\_\_\_\_
  - Hemorrhoids \_\_\_\_\_
  - Hernea \_\_\_\_\_
  - Urine Infections – Frequent \_\_\_\_\_
  - Blood in Urine \_\_\_\_\_
  - Urination  Overnight > Than Twice \_\_\_\_\_
  - Painful  Loss of Control \_\_\_\_\_
  - Kidney Stones \_\_\_\_\_
  - Venereal Disease \_\_\_\_\_
  - Urethral Discharge \_\_\_\_\_
  - Weight Loss – Recent \_\_\_\_\_
  - Anemia  Bruise Easily \_\_\_\_\_
  - Cancer \_\_\_\_\_
  - Diabetes \_\_\_\_\_
  - Stroke \_\_\_\_\_
  - Tremor/Hands Shaking \_\_\_\_\_
  - Muscle Weakness \_\_\_\_\_
  - Numbness/Tingling sensations \_\_\_\_\_
  - Headaches – Frequent \_\_\_\_\_
  - Arthritis/Rheumatism \_\_\_\_\_
  - Osteoporosis \_\_\_\_\_
  - Back Pain – Recurrent \_\_\_\_\_
  - Bone Fractures/Joint Injury \_\_\_\_\_
  - Gout \_\_\_\_\_
  - Foot Pain/Cold Numb Feet \_\_\_\_\_
  - Rashes  Hives \_\_\_\_\_
  - Psoriasis/Eczema \_\_\_\_\_
  - Memory Loss \_\_\_\_\_
  - Moodiness – Excessive \_\_\_\_\_
  - Phobias \_\_\_\_\_
  - Mental Illness \_\_\_\_\_
  - Frequent Infections \_\_\_\_\_
  - Diphtheria \_\_\_\_\_
  - Tetanus \_\_\_\_\_
  - Chicken Pox  Mumps  Polio \_\_\_\_\_
  - Measels  Rubella  Rheumatic Fever \_\_\_\_\_
  - Scarlet Fever  Tuberculosis  Herpes \_\_\_\_\_
  - Other \_\_\_\_\_
  - Other \_\_\_\_\_
- FEMALES: Please Complete  
 PLANNING PREGNANCY? YES  NO   
 PREGNANT? YES  NO   
 Menstrual Flow:  
 Regular  Irregular  Pain/Cramps  
 \_\_\_ Days of Flow \_\_\_ Length of Cycle  
 Date-1<sup>st</sup> day of last period \_\_\_\_\_  
 \_\_\_ Pain/Bleeding during or after Sex  
 Number of:  
 \_\_\_ Pregnancies \_\_\_ Abortions  
 \_\_\_ Miscarriages \_\_\_ Live Births  
 Birth Control Method \_\_\_\_\_  
 B.C. Pill (Name) \_\_\_\_\_  
 \_\_\_ Flushing/Menopause  
 Date of last PAP test \_\_\_\_\_  
 \_\_\_ Normal  Abnormal  
 Date of last mammogram \_\_\_\_\_  
 \_\_\_ Normal  Abnormal

**HOSPITALIZATIONS:**

Date	Reason

**FAMILY HISTORY:**

Please give the following information about your immediate family (parents, brothers, sisters, spouse and or children)

RELATIONSHIP	AGE	ILLNESS
		DIABETES
		CANCER
		BLOOD DISEASE
		GLAUCOMA
		HIGH BLOOD PRESSURE
		BACK PROBLEMS
		TUBERCULOSIS
		RHEMATOID ARTHRITIS
		EPILEPSY
		GOUT
		HEART DISEASE

# Massage Client Waiver

At Fountain Chiropractic and Wellness Center, it is our intention to provide our guests with professional and therapeutic services in a relaxing and friendly environment. We tailor each treatment to our client's individual needs. The following policies and procedures serve as a guide for our first-time and repeating guests. Feel free to ask questions. Please read each section and initial.

## 1. Reservations and Scheduling

- We believe that your time is valuable, as is ours. In an effort to maintain efficiency and ensure each client an optimal experience, we ask that you observe our scheduling guide.
- In order to avoid scheduling mistakes, all massage appointments must be made through the front desk. This can be done in person or over the phone.
- Standing appointments (appointments booked at specific intervals, like every Tues@11 or every other Mon@3.) are beneficial for people with predictable schedules
  - However, those with fluctuating schedules, standing appointments create scheduling difficulties as there are continuous reschedules, cancelations and confusions. We are happy to book standing appointments for any and all that are able to maintain the standing arrangements.

## 2. Time

Our highly trained therapists work tirelessly to make the most out of every minute of each client's time with us. In order to stay on schedule and give every client our full attention we have adopted the following timeline.

- For first time clients, we ask that you arrive 10-15 minutes early to allow time to fill out paperwork.
- It's best to use the restroom before your appointment begins to insure your comfort through your massage
- The first minutes of each massage will be spent going over your medical intake with your therapist and you will be given a few minutes, privately, to dress down to your comfort level.
- The final minutes of each session will be spent getting dressed.
- For 60 minute massages you will receive 50+ minutes of hands-on therapy.
- For 90 minute massages you will receive 80+ minutes of hands-on therapy.

## 3. Cancellation Policy

We understand that unanticipated events happen occasionally in everyone's life. In our desire to be effective and fair to all of our clients, and out of consideration for our therapists' time, we have adopted the following policies.

- We ask that you call to cancel (or hopefully re-schedule) your appointment as soon as you become aware of your inability to attend.
- 30-60 minute massages require a 24 hour notice for cancellation.
- 90+ minute massages require a 48 hour notice for cancellation
- If you do not meet the cancelation deadline, you will be subject to a cancellation fee of the cost of the massage.
  - 60 minute-\$70, 90 minute-\$126, 120 minute-\$168
- If you do not show up and do not call to cancel, you will be considered a no-show and will be charged the full amount for the refused service.
- **All cancellation fees must be collected before future services will be scheduled or rendered.**
- Any multiple or consecutive violations of the cancelation policy will result in required pre-pay for future services.

\*These policies are not intended to punish but simply to maintain respect for our therapists and compensate them for their time. That said, we strive to accommodate our clients, whenever possible.

#### **4. Pricing (Prices are subject to change.)**

Our therapists are highly trained in anatomy and physiology and have dedicated much of their free time to continuing education programs and honing their skills beyond the minimal certification requirements. We have based our prices on local, fair market rates and on the therapists' qualifications.

- 1 hour massage-\$70
- 90 minutes-\$126 (includes 20% gratuity)
- 2 hour massage-\$168 (includes 20% gratuity)

Add-Ons-\$10 for 1 Hour or less; \$20 for 90+ Minutes

- Hot stone
- Cupping
- Aromatherapy
- Graston Technique
- Prenatal
- CBD

Extras (can be done without a massage)

- Cupping-\$65
- Kinesiology Taping-\$15

#### **5. Medical Conditions and Safety**

While massage therapy is amazingly therapeutic for the mind, body and soul, it is **not a substitute for medical treatment**. Our therapists do not diagnose or treat medical conditions. Please, make an appointment with Dr. Waters or your primary care physician if you are experiencing any medical conditions. For your health and safety, read the following instructions carefully.

- It is the responsibility of the client to inform the therapist of **ANY and ALL Medical Conditions**, including but not limited to: known or suspected illnesses, active infections of any kind, chronic conditions, medications, heart problems, seizures, headaches, sprains, concussions, soft tissue or bone injuries, etc...
- Certain active infections can spread through the vascular or lymph systems during a massage. For this reason, it is best you call the office as soon as you are aware of an infection. The therapist will decide if it is safe to go ahead with the massage, or if a reschedule is required.
- If you weren't able to call ahead, be sure to inform your therapist of any active infection, before the massage.
- For returning clients, any changes to medical conditions or medications must be reported to your therapist.
- Notify your therapist if you are pregnant. A specialty prenatal massage will be administered.
- Please, reschedule your massage if you have had infection, fever vomiting, diarrhea or cold/flu in the last 48 hours, or if you know/believe you are contagious
- **Do not come for a massage while under the influence of drugs or alcohol.**
  - If it is determined that a client is under the influence of drugs or alcohol at any point during the appointment, the massage will be terminated and the client will pay full price for reserved services.

## 6. Quality and Comfort

Your comfort and well-being are paramount, and while our therapists are some of the best around, they cannot read minds. Your communication and participation during your session are key to a relaxed, top-notch experience that is tailored to your preferences.

- It is the client's responsibility to alert the therapist of any pain or discomfort during the massage. Proper adjustments will be made immediately upon notification.
- The client may stop the massage at any point if they are not feeling well.
- Please communicate any desired change to comfort settings: temperature, body positioning, massage pressure, scents and sounds, etc.
- Talk during the session will be guided by the client. The therapist will take the lead of the client and talk as little or as much as the client is feeling, so feel free to chat or not.
- Some people experience soreness or slight bruising after a massage. Generally this nothing to be concerned about and will subside quickly. Contact us if you have concerns or questions.
- It is important to drink a lot of water after a massage to help rid the body of the newly released toxins. This will also reduce soreness.
- Because every employee at Fountain Chiropractic is bound by the patient confidentiality. Of HIPAA (see your signed privacy act) anything you say during your massage will never be repeated to anyone not employed by Fountain Chiropractic.

- Massage therapists are mandatory reporters. If a client informs one of our therapists that they are intending to harm themselves or anyone else, the therapist is required by law to report the intended harm to the relevant authority.

## **\_\_\_\_\_ 7. Code of Conduct**

**Fountain Chiropractic is a professional establishment and will not tolerate any sexual misconduct at any level! Any sexually explicit conduct will result in immediate termination of the session. The client will be required to pay for the full session regardless of time remaining. The following is a list of behaviors that will result in immediate termination of the session.**

- Sexual talk, innuendo, jokes or solicitation
- Any grabbing, touching or groping of the therapist
- Sexually explicit movements of any kind
- Client undraping: The client will be draped with a sheet throughout the session. The only area to be undraped is the area receiving treatment
- Any other behaviors that allude to a sexual nature...

**If a client sexual misconduct results in session termination, the client will be released as a patient and no longer allowed to receive any services at Fountain Chiropractic. Our therapists reserve the right to press criminal charges against any sexual abuse.**

We are honored that you chose us to provide your therapeutic needs. Now, it's time to take a deep breath, clear your mind and let us take great care of you while you are here.

**I have received the policy statement, and have read and agree to the policies therein.**

**Client Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Client Signature:** \_\_\_\_\_