Welcome To LIVE LONG & Prosper Chiropractic LLC

We are glad that you are considering us, in assisting with the natural healing process of Chiropractic. Chiropractic simply aides in the natural healing process. Pain is simply just the warning sign that something is **seriously wrong**. The condition that we treat is SUBLUXATION. A subluxation occurs when the spine becomes misaligned causing it to function abnormally. This usually pinches the nerve and causes pain. A SUBLUXATION is a condition or disease of the spine that interferes with the normal function of the body and its systems. This condition is serious and needs to be corrected immediately. Delaying correction or not following through with treatment can be detrimental to your health.

We need you to participate in correcting your condition.

1. We expect you to keep your appointments as best you can. If an emergency comes up where you cannot attend your next appointment, you need to call us right away and reschedule as soon as you can, to keep your care plan on schedule. You will need to make up any missed appointments as missed appointments cause patients to lose ground and not get well as expected. As a courtesy, we will call you to remind you of your missed appointment.

2. Attending the Chiropractic themed Life Advancement Class with your spouse, relative and/or friend is mandatory as part of your care plan. Besides, they are very informative and imperative for your recovery.

3. "Small acts, when multiplied by millions, change the world." This is your opportunity to help change the world of someone close to you who means a lot. Share your positive experiences of corrective care with those you come in contact with. Share Google reviews, refer a friend, bring in a family member. Share your changes, to start changing this world for good. Chiropractic is a drug-free, natural approach to making someone's life better. Be their hero!

4. Keeping your account up to date. Payments are due at the time of service. Pre-pay is encouraged to keep your costs down. Any balance not paid after 60 days is going to be charged an interest rate at the maximum rate of Washington State Law. Balances over 90 days, unless specifically noted, will be placed in collections. Patients are responsible for any and all collection costs. And a $20 service charge will apply for any returned checks.

5. Dr Daniel Long and his staff always encourage any of your questions concerning these and any other Chiropractic issues. Please feel free to also communicate with us, things you think we could do better to serve you.

INFORMED CONSENT, DISCLOSURE OF PROTECTED HEALTH INFORMATION, PAYMENT AND HEALTHCARE, EXPECTATIONS AGREEMENT

1. **LIVE LONG & Prosper Chiropractic** Privacy Notices has been provided to me, I have read, understand and agree to abide the guidelines. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the practice to provide treatment to me and also necessary for the practice to obtain payment for that treatment and to carry out health care operations. The practice will provide me a copy of this consent **at my request** for my own records at home.
2. **LIVE LONG & Prosper Chiropractic** reserves the right to change its privacy practices that are described in it's Privacy Notice, in accordance with applicable Law.
3. I understand that, and consent to, the following

a. Appointment reminders are a courtesy to be used only by **LIVE LONG & Prosper Chiropractic**, and may consist of mailers, texts, phone calls, emails and any other form of communication I provide.

b. I have a right to request that **LIVE LONG & Prosper Chiropractic** restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, **LIVE LONG & Prosper Chiropractic** is not required to agree to any restrictions that I have requested.
c. This Consent is valid for seven years; I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the practice has already taken action in reliance on this consent.
d. If I revoke this consent at any time, **LIVE LONG & Prosper Chiropractic** has the right to refuse treatment.
e. If I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then **LIVE LONG & Prosper Chiropractic** will not treat me.
f. My questions can't be answered if I don't ask
g. **Honesty and clear communication** are best for respecting others. I will be honest with my intentions and communicate when I want to end care, miss appointments and so on.

OPEN DOOR/ROOM ADJUSTING POLICY

It is the practice of this office to provide chiropractic care in an "open door" adjusting environment. Open door adjusting involves patients being seen in an adjusting area by others in the office. Patients are within sight of one another and some ongoing routine details of care of discussed within earshot of other patients and staff. These are known as "incidental disclosures" of health information. It is our view that the kinds of matters related in an "open door adjusting" environment are incidental matter. If I choose not to be adjusted with the door open, it is my responsibility to assure the door is closed to my satisfaction.

LIVE LONG & Prosper Chiropractic LLC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

This practice is committed to maintaining the privacy of your Protected Health Information (PHI), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI.

CONSENT

The practice may use and/or disclose your PHI provided that it first obtains a valid Consent signed by you. The Consent will allow the Practice to use and/or disclose your PHI for the purposes of:

(a) ***Treatment*** **–** In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs. For example, a physician treating you for kidney problems may need to know the results of your latest physical examination by this office.

(b) ***Payment*** – In order to get paid for services provided to you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements. For example, the Practice may need to tell your insurance plan about treatment you are going to receive so that it can determine whether or not it will cover the treatment expense.

(c) ***Health Care Operations*** – In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose you PHI. For example, the Practice may use your PHI in order to evaluate the performance of the Practice's personnel in providing care to you.

NO CONSENT REQUIRED

The practice may use and/or disclose your PHI, without a written Consent from you, in the following instances:

(a) ***De-identified Information*** – Information that does not identify you and, even without your name, cannot be used to identify you.

(b) ***Business Associate*** – To a business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.

(c) ***Personal Representative*** – To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

(d) ***Emergency Situations*** – For the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible; or to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

(e) ***Communication Barriers*** – If, due to substantial communication barriers or inability to communicate, the Practice has been unable to obtain your Consent and the Practice determines, in the exercise of its professional judgment, that your Consent to receive treatment is clearly inferred from the circumstances.

(f) ***Public Health Activities*** – Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease.

(g) ***Abuse, Neglect or Domestic Violence*** – To a government authority if the Practice is required by law to make such disclosure. If the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm.

(h) ***Health Oversight Activities*** – Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.

YOUR RIGHTS

You have the right to:

(a) Revoke any Authorization and/or Consent, in writing, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer. Please allow a reasonable processing time for the change in our procedure to be completed.

(b) Request restrictions on certain use and/or disclosure of you PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request (within 60 days) unless the information is needed in order to provide you with emergency treatment.

(c) Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.

(d) Inspect and copy your PHI as provided by law. To inspect and copy your PHI, you must submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request. In certain situations that are defined by law, the Practice may deny your request, but you will have the right to have the denial reviewed as set forth more fully in the written denial notice.

(e) Amend your PHI as provided by law. To request an amendment, you must submit a written request to the Practice's Privacy Officer. The Practice has 60 days to notify you

acceptance or refusal to amend. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.

(f) Receive an accounting of disclosures of your PHI as provided by law. To request an accounting, you must submit a written request to the Practice's Privacy Officer. Practice will act on the request for an account of disclosure within 60 days. The request must state a time period which may not be longer than 6 years and may not include dates before April 14, 2003. The request should indicate in what form you want the list (such as a paper or electronic copy). The first list you request within a 12-month period will be free, but the Practice may charge you for the cost of providing additional lists. The Practice will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred.

(g) Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's Privacy Officer.

(h) Complain to the Practice or the Secretary of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

(i) To obtain your own copy, more information on, or have your questions about your rights answered,
you may contact us at (253) 850-2225.

PRACTICE'S REQUIREMENTS

The Practice:

(a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

(b) Is required by State law to maintain a higher level of confidentiality with respect to certain portions of your medical information that is provided for under federal law. In particular, the Practice is required to comply with the following State statutes:

1) Is required to abide by the terms of this Privacy Notice.

2) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice Provisions effective for all of your PHI that it maintains.

3) Will distribute any revised Privacy Notice to you prior to implementation.

4) Will not retaliate against you for filing a complaint.

This Notice is in effect as of 6/14/18. This notice, and any alterations or amendments made hereto, will expire seven years after the date upon which the record was created.

LIVE LONG & Prosper Chiropractic LLC

Patient Agreement

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

We do not offer to diagnose or treat any disease or condition other than the vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by other. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

TERMS TO KNOW:

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

Health is a state of optimal physical, mental, and social well-being, not merely the absence of infirmity.

Vertebral Subluxation is a misalignment of one or more of the 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 its maximum health potential.

I have been advised of the importance of my condition and the necessary treatment required to stabilize and achieve optimum benefits.

_____I choose not to follow recommendations and release all liability of the doctors and staff at Live Long & Prosper Chiropractic in the even of my worsening of my condition, degeneration, disabling condition, or surgery that inadequate care may result in.

_____ I choose to follow my care recommendations

Rules for patient acceptance:

- ALWAYS BE UPFRONT AND HONEST. We respect you by being honest and upfront with you.
- All your questions are important - **please ask them**.
- We cannot help you if you're not here. **You must make all appointments**.
- Please program our office numbers into your cell phone. Call **(253) 850-2225** Text **(253) 260-5450**
- To GET BETTER FASTER and MAINTAIN YOUR SPINAL CORRECTIONS, **you must attend a chiropractic Life Advancement Class for free.**
- Should you decide to end your care prematurely **all pre-payments will be refunded (minus the regular undiscounted amount of the care you have already received).**
- Tell your friends and family about your chiropractic experience with us.

Patient/ Guardian Signature:_____ Date:_____

Patient/ Guardian Printed:_____

Confidential Patient Information

Name: _____ Hm Phone: _____ Wk/Cell Phone: _____

Address: _____ City: _____ St: _____ Zip: _____

Date of Birth: _____ Marital Status (circle one) M S D W Age _____

Social Security Number _____-____-_____ E-mail Address _____

Occupation: _____ **Employer:** _____

Work Address: _____ City, St, Zip: _____

Spouse's Name: _____ # of Children: _____

Name & Age _____ Name & Age _____

Name & Age _____ Name & Age _____

We are a family clinic and encourage all family members to "grow healthy" and stay healthy so there is less to fix as an adult, has anyone in your family received chiropractic care before? Y / N How long ago? _____

Have you ever had chiropractic care before? Y / N How long ago? _____ ***Are you pregnant***? _____

Reason you went to chiropractor: _____ Frequency _____

Why did you stop seeing that doctor? _____ Have you taken medication recently?

Who may we thank for referring to our office: _____ type: _____

Have you had surgery related to why you are here? Y / N Date: _____

What were the surgery(s) [including C- Section]? _____

_____

Beyond feeling better, what is your reason to be healthier? _____

_____

Are you wanting to fix the problem, temporary relief, or to maintain? _____

ACCIDENTS AND INJURIES Please circle one: work auto sports other _____

_____

Date/Time: _____ Location: _____

YOUR auto insurance co: _____ Phone: _____

THIRD PARTY insurance co: _____ Phone: _____

Hospitalized? Y / N Location: _____ Date: _____

As a clinic, we value respect, honesty & clear communication. We are honest with you in all aspects and expect the same in return. We also have the right to terminate your care in our clinic, if our clinic or anyone in it is treated inappropriately. Due to changes in health insurance fees, patient self billing has become a much more cost effective way for you, the patient, to get reimbursement for your care. Self billing allows us to keep our fees low so you can get the care you need without any added cost. Therefore, our policy is that all payment is due at the time of service and bills will no longer be sent to your insurance provider by us**. Statements will be provided for individuals to submit their own bills ensuring that as your insurance provider pays for your care, they will send the reimbursement check directly to you.** All charges are due when services are rendered**…**

Method of payment ( ) Check ( ) Cash ( ) Credit Card ( ) Care Credit ( ) HSA

*If you agree, please sign both statements

I authorize **[IVE [ONG & Prosper Chiropractic LLC** to render necessary services to me and understand that I am responsible for all charges incurred. Patient Signature: _____

_____

I have received, read and understand the privacy policy, compliance notice, my rights, my consent statements

Patient Signature: _____ **Date:** _____

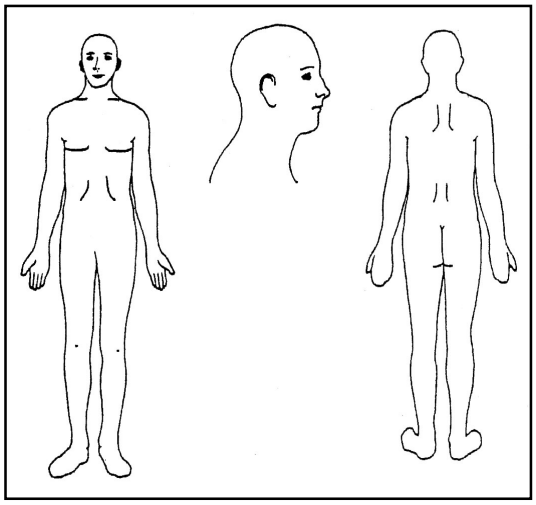
Parent or Legal Guardian Authorizing Care: _____

THANK YOU FOR ALLOWING US TO SERVE YOU!

Health concerns- Fill in ALL areas that you have experienced in the last 12 months

☐ CHEST PAIN	☐ G.I. ISSUES	☐ AUTISM	☐ CRAMPS
☐ HEADACHES/MIGRAINS	☐ CONSTIPATION	☐ DEPRESSION	☐ CYSTS
☐ EYE PAIN	☐ BLADDER ISSUES	☐ ANXIETY	☐ IRREGULAR CYCLES
☐ NECK/SHOULDER PAIN	☐ DIARRHEA	☐ STRESS	☐ REPRODUCTIVE ISSUES
☐ BACK PAIN upper mid lower	☐ FOOD SENSITIVITIES	☐ CANCER	☐ PROSTATE ISSUES
☐ HIP PAIN	☐ GALLBLADDER ISSUES	☐ ULCERS	☐ TONSILS/ADENOIDS ISSUES
☐ KNEE/ANKLE/FOOT PAIN	☐ HEART DISEASE	☐ HERNIAS	☐ THYROID ISSUES
☐ ADD/ADHD	☐ KIDNEY ISSUES	☐ COLDS	☐ POOR CIRCULATION
☐ EAR INFECTIONS/ACHES	☐ METABOLISM ISSUES	☐ VERTIGO	☐ EPILEPSY/SEIZURE
☐ REFLUX/HEARTBURN	☐ CHRONIC COUGH	☐ BALANCE/COORDINATION	☐ DIABETES
☐ PNEUMONIA/BRONCHITIS	☐ CHRONIC FATIGUE	☐ VISION/HEARING LOSS	☐ ALLERGIES
☐ FOCUS/MEMORY ISSUES	☐ INSOMNIA	☐ TINNITUS/RINGING EARS	☐ DIZZINESS
☐ SENSORY PROCESSING/SPECTRUM DISORDER	☐ SPEECH ISSUES	☐ HIGH BLOOD PRESSURE	☐ ECZEMA

PLEASE MARK AN X ON THE DIAGRAM BELOW WHERE YOUR PROBLEMS ARE



What are the 3 most concerning

1.What is the PRIMARY concern that brought you in today?

_____

Pain scale of 1-10 (10 being most severe). _____
When did this start?_____
Is it getting … (circle) better worse same
Are you taking medications? Y / N
What medication? _____
Please describe the problem: _____

_____

What makes it worse?_____
What makes it better?_____
What parts of your life is this interfering with?

2.What is the 2nd concern that brought you in today?

_____

Pain scale of 1-10 (10 being most severe). _____
When did this start?_____
Is it getting … (circle) better worse same
Are you taking medications? Y / N
What medication? _____
Please describe the problem: _____

_____

What makes it worse?_____
What makes it better?_____
What parts of your life is this interfering with?

_____

3.What is the 3rd concern that brought you in today?

_____

Pain scale of 1-10 (10 being most severe). _____
When did this start?_____
Is it getting … (circle) better worse same
Are you taking medications? Y / N
What medication? _____
Please describe the problem: _____

_____

What makes it worse?_____
What makes it better?_____
What parts of your life is this interfering with?

_____

List other chiropractic or medical doctors you have consulted for these conditions.

Additional notes:

1. _____
2. _____
3. _____

Confidential Female/Pediatric Information

If this is for a child who is a patient, fill out pregnancy information during this child's pregnancy. If you are the patient and are currently or recently been pregnant, fill out info related to you and your pregnancy.

Name: _____ Date of Birth: _____ Date for Today:_____

Do/did you exercise? Y/ N frequency & length_____exercise:_____

Do/did you take supplements? Y/ N frequency & length_____

supplements:_____

Describe your diet:_____

Do/did you smoke? Y/ N how much _____ Do/did you drink? Y/ N how much _____

Job details: What type of work do you do? Office work Physical labor Homemaker

How many hours a day are you seated? _____ How many hours a day are you on your feet/moving?_____

How intense is your daily physical activity? Light Moderate Heavy

MOM how many pregnancies have you had? (1st one put N/A)_____ # of Miscarriages_____

Any ultrasounds or other radiation Y / N How many_____ Reason_____

Invasive procedures during the pregnancy Y / N please explain_____

Traumas or Illness during pregnancy?_____

Position during labor: _____ Was labor induced? Y / N Reason_____

Birth location_____ Birth assistant type_____

Was mom administered drugs? EpiduralMorphine Other_____

Interventions during birth? No Forceps C-section Vacuum How long was labor?_____

Was there any evidence of birth trauma to the infant? Mark all that apply.

☐ Bruising ☐ Stuck in canal ☐ Respiratory depression ☐ Odd shaped head ☐ Cord around neck

Were there any other complications during birth or congenital anomalies/defects present? Y/ N Please explain

_____

Child is biological Adopted fostered other_____

Mother's Name:_____ Father's Name_____

Sibling M / F Age __ Name_____ Ever seen a chiropractor? Y/ N Want to? Y/ N

Sibling M / F Age __ Name_____ Ever seen a chiropractor? Y/ N Want to? Y/ N

Sibling M / F Age __ Name_____ Ever seen a chiropractor? Y/ N Want to? Y/ N

Was child breast fed? Y / N Lactation problems? Y / N Formula fed? Y / N Cow milk? Y / N

Solid foods? Y / N Age introduced_____ Food intolerances? Y / N reaction_____

Did your child favor turning their head to one side while sitting, sleeping or nursing? Y / N Side_____

At what age did your child start…roll over_____ crawl_____ walk_____

Describe any complications or delays with motor development and speech development._____

_____

Any falls from couches, beds, change tables…? Y / N_____

Has the child been or plan to be vaccinated? Y / N Partial Alternative schedule Homeopathic

Have you noticed negative reactions? Y / N _____

Please check all experienced in the last 12 months

☐ Bedwetting	☐ Behavior issues	☐ Feeding difficulty	☐ Respiratory issues	☐ Colic
☐ Constipation	☐ Food sensitivities	☐ Odd head shape	☐ Walking development	☐ Fever
☐ Torticollis	☐ Heart conditions	☐ Sleep difficulty	☐ Speech development	☐ Skin issues