NETWORK SPINAL ANALYSIS (NSA)

Consent Form

I hereby request and consent to receiving spinal care, including wellness education in this office by chiropractors who provide Network Spinal Analysis (NSA) Care, a low force approach which has unique outcomes and clinical results. These practitioners choose to practice NSA, as he/she is professionally and personally confident in regard to the safety and effectiveness of this form of care.

This office provides care in accordance with the *Council on Chiropractic Practice Guidelines* and the *Canon of Ethics of the Association for Network Care,* and my doctors have been trained in traditional chiropractic care and certified in the procedures of Network Spinal Analysis Care.

The purpose of this consent form is to help me better understand the nature of the services offered in this office and our mutual responsibilities. This fosters a more effective relationship and avoids misunderstandings regarding expectations. Having well understood expectations is anticipated to promote a greater sense of safety and healing.

NSA does not attempt to manually, or by instrument, manipulate spinal fixations structurally (often associated with a snapping or popping sound), nor does it directly treat painful areas of the spine and body. *Instead, by enhancing my body's awareness of itself and specifically my spine, I understand I can develop new strategies for healing, adapting to stress, and experiencing wellness. These strategies promote spontaneous self-correction and self-regulation of spinal tension patterns and healing.*

NSA consists of gentle touch contacts along the neck and back to achieve greater communication between the brain and body, and new sensory and motor strategies. NSA adopts an approach associated with somatic (body/spinal awareness) training. There is a body of research characterizing NSA care and documenting its unique and significant wellness benefits. I understand I may obtain copies of published research articles and/or abstracts in this office

I am aware that I will be receiving gentle touch Network Adjustments, also called entrainments. Assessments of my progress will include monitoring of my spine and body awareness, responsiveness to inner rhythms, tension, and ease patterns. At regular intervals, following commencement of care, re-assessments will be performed. These will include my personal perception of my wellness and my awareness of my spine and body-mind changes. My chiropractors will report to me the improvement in my spinal and nervous system integrity and my ability to self-regulate tension and to re-organize my spine.

NSA is advanced through a series of Levels of Care. Each level of care involves the development of new and unique spontaneous spinal wave motions, other body movements, and oscillations. These waves, which are suggested to be associated with the greater spinal stability, the re-distribution of energy, and the transfer of internal information are also associated with greater wellness, improved quality of life, and increased life enjoyment.

I also understand that, in addition to NSA care and wellness education, my practitioners may perform additional examinations or assessments and offer health/spinal care or advice that is consistent with my individual needs.

Please Read and Sign the Following:

It has been explained to my satisfaction, and I understand that the care offered at this office is not a form of, or replacement for, the diagnosis or treatment of any symptom, disease, or malady. Instead, it is a form of wellness care and self-education that empowers my connection with my body-mind and develops new strategies for spinal and nervous system integrity and wellness. It develops new capacities in my body for the identification of, spontaneous release of, and redirection of tension, including those that are unique to NSA care.

It is common for people receiving NSA care to breathe more deeply and more fully, engaging the spine with their respiration, to spontaneously adapt postures that release or redistribute tension, to bust stress, and to experience more of their inner life energy.

I understand it is common to experience a wider range of motion and emotion during care. It is common, as care progresses, to find new options in the body and in life, which often lead to significant life changes. *This form of care is NOT suggested for those individuals who wish to remove a symptom or condition without the occurrence of other fundamental changes in their lives. The care in this office often promotes significant changes in health choices, lifestyle, experience of the body-mind, emotion, and consciousness.*

Rather than simply attempting to return me to my previous state minus a symptom, these chiropractors instead choose to help me achieve new levels of wellness and life potential that I may never have had before.

Although in this office we seek to help develop new strategies for wellness and spinal and nerve system integrity, as a chiropractor the sole condition of concern is that of the vertebral subluxation. Our insurance carrier requires that the following information be given to you and signed by you prior to commencing care.

In Network Care, we categorize these subluxations into two categories, a structural segmental distortion and a spinal cord/nerve elongation or stretching. Through the gentle force applications at the spine to enhance spinal and nerve system integrity subluxations are corrected. The only condition we offer to diagnose and correct is the vertebral subluxation and loss of spinal and neural integrity in relationship to this. We do not offer to treat any other condition, disease or symptom. If during the course of our spinal assessment/examination we encounter non-chiropractic or unusual findings, we will advise you of this. If you desire advice on further diagnosis or treatment of this condition, situation or circumstance, we will recommend that you seek the services of another health care provider whose practice is geared towards such differential diagnosis and treatment.

I have read, or have had read to me, this CONSENT TO RECEIVE NETWORK SPINAL ANALYSIS (NSA) CARE and *understand that the care in this office is different from what many consumers may expect from chiropractors practicing manipulative therapy. I agree to receive care, which consists of or includes NSA care and wellness education. I understand that I am not passive in this process, but that I am an active participant in my care and in my healing.*

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PRINTED NAME OF PRACTICE MEMBER

______________________________ ______________________

SIGNATURE OF PRACTICE MEMBER DATE

Office Policy

We are committed to providing you with the best possible care. If you have chiropractic benefits, we are anxious to help you receive the maximum allowable benefits. In order to achieve these goals, we need you to understand our policies.

Co-payments and/or payments are due at the time of your visit. Payments can be made by credit card, personal check or cash. Patients with percentage co-payments will be billed as the information is received from your insurance company.

Your insurance is a contract between you, your employer and the insurance company. We are not a party to your contract. As a courtesy to our patients, our office will verify your chiropractic benefits with your insurance company. ***Our relationship is with you, not your insurance company, we recommend you also verify your chiropractic coverage with your insurance company. Any inaccurate information given to our office by an insurance representative concerning your coverage is your responsibility.***

If you do not have your insurance card for verification purposes, you will be responsible for $60 at time of visit until current insurance information can be verified. No visits will be backdated to the insurance company.

You are responsible for obtaining a Primary Care Physician (PCP) referral or script if required by your insurance company. If you do not have the required referral or script for your visit, you will be responsible for $60 at time of visit until one can be obtained. Visits will not be backdated to the insurance company.

You are responsible for tracking the number of visits allowed by your insurance company, expiration dates and the number of visits on your PCP referral and treatment plan.

I authorize the release of any medical or other information necessary to process my claims. I also request payment of government benefits either to myself or to the party that accepts the assignment. (Box 12 on CMS-1500)

I authorize payment of medical benefits to the undersigned physician or supplier for services described below. (Box 13 on CMS- 1500)

If you have any questions, please do not hesitate to ask. We are here to assist you in any way possible.

I have read and understand the above information.

Signed:______________________________________ Date:____________________

PATIENT CONSENT

CONSENT FOR TREATMENT:

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

RELEASE OF INFORMATION:

By signing this form, you are granting consent to Network Chiropractic of Somerset to use and disclose your protected health care information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change, if we change our notice, you may obtain a copy of our revised notice by telephoning our office at (732) 398 – 1600. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment and health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we our bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

MEDICARE AND MEDICAID CONSENT RELEASE INFORMATION:

I certify that the information give to me is applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim.

X______________________________________
Print Patients Name

X______________________________________
Patient Signature

X______________________________________
If not patient, print name and relationship

X______________________________________
Witness

Date: ____________________

CONFIDENTIAL PATIENT HEALTH RECORD

Date: ____________________

PERSONAL HISTORY

Name: ____

Address: ____

City ______________________ State: ____ Zip: __________

Social Security #: ______________________________________

Driver's License #: ______________________________________

Business Employer: ______________________________________

Occupation: ______________________________________

☐Married ☐Single ☐Divorced ☐Widowed

Type of Work: ______________________________________

Referred To This Office By: ______________________________

Name & Number of Emergency Contact: ______________________

Birth Date: ______________ Age: ______________

Sex: Male / Female

Home Phone: ______________________________________

Cell Phone: ______________________________________

E-mail Address: ______________________________________

Fax #: ______________________________________

Business Phone: ______________________________________

Spouse's Name: ______________________________________

Names & Ages of Children: ______________________________

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Relationship: ______________________________________

Who is Responsible for your bill ☐I am ☐Spouse ☐Worker's Comp ☐Auto Insurance ☐Medicare ☐Medicaid

Personal Health Insurance Carrier: ______________________

Insured Person's Name: ______________________________

Insured Person's Date of Birth: ______________________

Insured Person's Social Security #: ______________________

Health Card ID #: ______________________________________

Group #: ______________________________________

Primary Care Physician: ______________________________

Pharmacy: ______________________________________

CURRENT HEALTH CONDITION

Chief Complaint (why you're here today) ______________________

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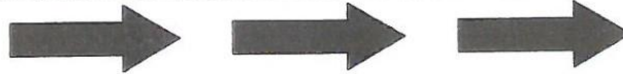
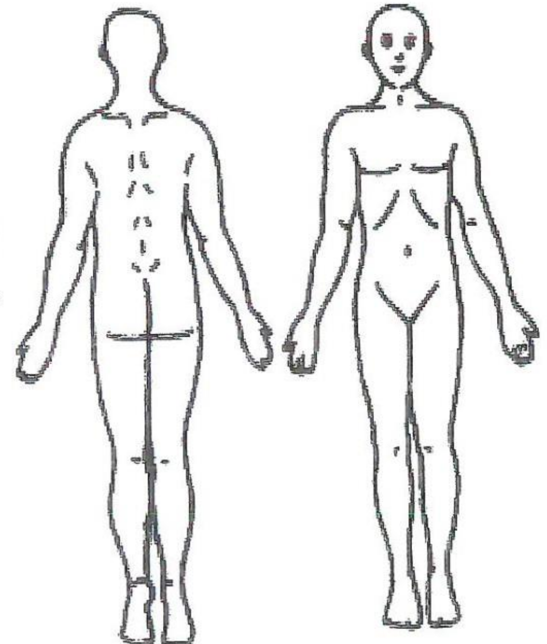
PLEASE OUTLINE ON THE DIAGRAM THE AREA OF DISCOMFORT





When did this condition begin? ______________________________

Has it ever occurred before? ☐ Yes ☐ No

Is condition: ☐ Auto Related ☐ Work Related ☐ Other ☐ No Injury

Explain: ____

Date of Accident: ______________________________________

Time of Accident: ______________________________________

Complaint/Pain Onset Date: ______________________________

If Work: Have you filed an injury report with your employer? ☐ Yes ☐ No

Claim #: ____

Other doctors seen for this condition? ☐ Yes ☐ No Who? ____________________

Type of treatment: ____________________ Results: ____________________

Drugs you now take: ☐ Nerve Pills ☐ Pain Killers ☐ Muscle Relaxers ☐ Blood Pressure Medicine ☐ Insulin ☐ Allergy Medicine

☐ Anti-Depressants ☐ Other: ____________________

Do you wear heel lifts? ☐ Yes ☐ No Side Lift ☐ Yes ☐ No Innersoles ☐ Yes ☐ No Arch Supports ☐ Yes ☐ No
Orthotics ☐ Yes ☐ No

Any other conditions you feel we should know about - even if unrelated? ____________________

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Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can effect your overall course of care.

REVIEW OF SYSTEMS – Please fill out all sections even if "NONE".

Constitutional: ☐ None
☐ Chills ☐ Weight Loss ☐ Daytime Somnolence ☐ Fatigue ☐ Fever ☐ Night Sweats ☐ Weight Gain

Eyes/Vision: ☐ None
☐ Blindness ☐ Field Cuts ☐ Blurred Vision ☐ Glasses/Contacts ☐ Cataracts ☐ Glaucoma ☐ Change in Vision ☐ Itching ☐ Double Vision ☐ Photophobia ☐ Eye Pain ☐ Tearing

ENT: ☐ None
☐ Bleeding ☐ Ear Pain ☐ Hoarseness ☐ Sinus Infections ☐ Dentures ☐ Fainting ☐ Loss of Smell ☐ Snoring ☐ Difficulty Swallowing ☐ Frequent Sore Throats ☐ Nasal Congestion ☐ Tinnitus (Ringing in Ears) ☐ Discharge ☐ Headaches ☐ Nose Bleeds ☐ TMJ ☐ Dizziness ☐ Hearing Loss ☐ PND (Post Nasal Drip) ☐ Ear Drainage ☐ History of Head Injury ☐ Rhinorrhea (Runny Nose)

Respiration: ☐ None
☐ Asthma ☐ Cough ☐ Coughing up Blood ☐ Shortness of Breath (SOB) ☐ Sputum Production ☐ Wheezing

Cardio: ☐ None
☐ Angina ☐ Palpitations ☐ Chest Pain ☐ PND ☐ Claudication ☐ SOB with Exertion ☐ Heart Murmur ☐ Swelling of Legs ☐ Heart Problems ☐ Ulcers ☐ Orthopnea ☐ Varicose Veins

Gastro: ☐ None
☐ Abdominal Pain ☐ Heartburn ☐ Stool Caliber ☐ Belching ☐ Hemorrhoids ☐ Stool Color ☐ Black Tarry Stools ☐ Indigestion ☐ Stool Consistency ☐ Constipation ☐ Jaundice ☐ Vomiting ☐ Diarrhea ☐ Nausea ☐ Vomiting Blood ☐ Difficulty Swallowing ☐ Rectal Bleeding

Female: ☐ None
☐ Breast Lumps/Pain ☐ Vaginal Bleeding ☐ Burning Urination ☐ Vaginal Discharge ☐ Cramps ☐ Frequent Urination ☐ Irregular Menstruation ☐ Urine Retention

Male: ☐ None
☐ Burning Urination ☐ Erectile Dysfunction ☐ Frequent Urination ☐ Hesitancy/Dribbling ☐ Prostate ☐ Urine Retention

Endocrine: ☐ None
☐ Cold Intolerance ☐ Goiter ☐ Diabetes ☐ Hair Loss ☐ Excessive Appetite ☐ Heat Intolerance ☐ Excessive Hunger ☐ Unusual Hair Growth ☐ Excessive Thirst ☐ Voice Changes ☐ Frequent Urination

Skin: ☐ None
☐ Changes in Nail Texture ☐ Itching ☐ Changes in Skin Color ☐ Paresthesias ☐ Hair Growth ☐ Rash ☐ Hair Loss ☐ Skin Lesions/Ulcers ☐ History of Skin Disorders ☐ Varicosities ☐ Hives

Nervous: ☐ None
☐ Dizziness ☐ Numbness ☐ Tremor ☐ Facial Weakness ☐ Seizures ☐ Unsteadiness of Gait ☐ Headache ☐ Sleep Disturbance ☐ Limb Weakness ☐ Slurred Speech ☐ Loss of Consciousness ☐ Stress ☐ Loss of Memory ☐ Strokes

Psychologic: ☐ None
☐ Anhedonia ☐ Depression ☐ Anxiety ☐ Insomnia ☐ Appetite Change ☐ Memory Loss ☐ Behavioral Change ☐ Mood Change ☐ Bipolar ☐ Confusion

Allergy: ☐ None
☐ Anaphalaxis ☐ Food Intolerance ☐ Itching ☐ Nasal Congestion ☐ Sneezing

Hematology: ☐ None
☐ Anemia ☐ Lymph Node Swelling ☐ Bleeding ☐ Blood Clotting ☐ Blood Transfusions ☐ Bruising ☐ Fatigue

PAST HEALTH HISTORY – Please fill out carefully as these problems can affect your overall course of care.

Childhood Illness: ☐ None
☐ ADD ☐ Allergies/Hayfever ☐ Asthma ☐ Atopic Dermatitis ☐ Cerebral Palsy ☐ Chicken Pox
☐ Depression ☐ Diabetes ☐ Fetal Drug Exposure ☐ Food Allergies ☐ Headaches ☐ Hepatitis
☐ Measles ☐ Mumps ☐ Rash ☐ Seizure Disorder ☐ Sickle Cell Anemia ☐ Spina Bifida
☐ Unusual Childhood Illnesses

Adult Illnesses: ☐ None
☐ Anemia ☐ Arthritis ☐ Asthma ☐ Cancer ☐ Chicken Pox ☐ CRPS (RSD)
☐ CVA (Stroke) ☐ Depression ☐ Diabetes (Insulin Dep) ☐ Diabetes (NIDDM - Noninsulin) ☐ Eye Problems ☐ Heart Disease
☐ Hepatitis ☐ Hypertension ☐ Kidney Disease ☐ Liver Disease ☐ Lung Disease ☐ Psychiatric Problems
☐ Seizures ☐ Similar Symptoms ☐ STD's ☐ Suicide Attempts ☐ Thyroid Problems

Surgeries: ☐ None
☐ Angioplasty ☐ Appendectomy ☐ Caesarian Section ☐ Cardiac Catheterization ☐ Carpal Tunnel Repair ☐ Coronary Bypass
☐ Cosmetic ☐ D&C ☐ Hemorrhoidectomy ☐ Hernia Repair ☐ Hysterectomy ☐ Joint Reconstruction
☐ Joint Replacement ☐ Laminectomy ☐ Mastectomy ☐ Pacemaker Insertion ☐ Spinal Fusion ☐ Tonsillectomy
☐ Gallbladder ☐ Rotator Cuff
☐ Other________________________________

Ob/Gyn: Describe:________________________________
☐ None

Injuries: Describe:________________________________
☐ None

Immunizations: ☐ None
☐ Flu ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ MMR ☐ Pneumonia
☐ PPD ☐ Small Pox ☐ TB ☐ Varivax

Non-Drug Allergies: Describe:________________________________
☐ None

FAMILY HISTORY

	Alive	Deceased	Condition
General Family	☐	☐	________
Father	☐	☐	________
Mother	☐	☐	________
Paternal Grandfather	☐	☐	________
Paternal Grandmother	☐	☐	________
Maternal Grandfather	☐	☐	________
Maternal Grandmother	☐	☐	________
Son(s)	☐	☐	________
Daughter(s)	☐	☐	________
Brother(s)	☐	☐	________
Sister(s)	☐	☐	________

SOCIAL HISTORY

Alcohol: ☐ None ☐ Beer ☐ Liquor ☐ Social Consumption ☐ Wine Amount________

Diet: ☐ High Fat Diet ☐ High Fiber ☐ High Protein ☐ High Salt Intake
☐ Low Calorie Intake ☐ Low Carbohydrate ☐ Low Fiber ☐ Low Salt ☐ Low Sugar

Education: Level or Degree Attained:________________________________

Substance: ☐ Denies Any ☐ Denies V Drugs Not Used Since________ Used Drugs For________

Tobacco: ☐ Denies Any Type________ Amount________