Tel: (954) 370-1900
Fax: (954)476-6281
1261 South Pine Island Road
Plantation, Florida 33324
drdavepopkin@gmail.com
drmgrundstein@gmail.com
website: www.drpopkin.com

CONFIDENTIAL PATIENT INFORMATION

Personal Information

Full name:	**Date:**
Address: Street	City State Zip
Home phone:	**Work phone:**
Cell phone:	**Email address:**
****Best place to contact you:**	**Can we leave a detailed message: Y/ N**
Date of birth:	**Age:**
No. of children:	**Pregnant?** Yes ☐ No ☐
Height:	**Weight:**
Driver's license number:	**SS#:**
Marital status: M S W D	**Spouse/guardian name:**
Occupation:	**Preferred Pharmacy Name & Phone #:**
Employer's name & address:	
Spouse's Occupation/Employer:	
Name of person responsible for account:	**Emergency Contact:**
Do you have insurance that covers Chiropractic/Medical Care? Yes ☐ No ☐	**Do you have Medicare coverage?** Yes ☐ No ☐
Name of Insurance Company:	
Insurance Policy number:	**Insurance Company phone number:**
Insurance Company address:	

Who may we thank for referring you? * _____ *

Addressing What Brought You Into This Office:

*If you have no symptoms or complaints and are here for Chiropractic/Medical Wellness Services, please skip to the **"General Health History"**.*

Health Concerns

Please list your health concerns according to their severity	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					
4.					

Print Patient Name:_____

Is your pain dull? Or is your pain sharp? Does it radiate anywhere? If so, where?

Since the problem started is it: About the same? ☐ Getting better? ☐ Getting worse? ☐

***What have you done for this condition? Was it of benefit? Did mainly temporary relief? Is that true so you haven't got to the underlying cause of the problem?

I do (do not) have a family history of this or similar symptoms (Please explain):

***Which activities aggravate your condition? (Affects persons life) tell me more about it

****Other doctors you have seen for this condition:

"Limited Scope" Chiropractor (focuses mainly on neck and back pain) Was experience + or -	☐
"Wellness" Chiropractor (focuses on health and well being as well as underlying cause of pain and health concerns)	☐
Medical Doctor	☐
Dentist	☐
Other (please describe)	☐

Doctor's details:

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

**** Have you been "forced" or "felt the need" to make any "positive" changes in your life due to this pain, illness, condition, etc?
(i.e., eat better, less alcohol or drugs, meditate or breathe more, less destructive sports, activities, etc.) If so, what?

****Is this condition interfering with any of the following?

Work ☐	Sleep ☐	Daily routine ☐	Sports/exercise ☐	Other ☐ (please explain):

Print Patient Name:_____

What lesson(s) have you taken home from your healing process to date?

_____

_____

General Health History

Often times, accumulation of life's stress can lead to health problems and influence our ability to heal. Please pay close attention to this as it will help us help you!

Have you had any surgery? (Please include all surgery)

1. Type:	When?	Doctor
2. Type:	When?	Doctor
3. Type:	When?	Doctor
4. Type:	When?	Doctor

Have you had any accidents and/or injuries: auto, work-related, or other? (Especially those related to your present problems).

1. Type:	When?	Hospitalized? Yes ☐ No ☐
2. Type:	When?	Hospitalized? Yes ☐ No ☐
3. Type:	When?	Hospitalized? Yes ☐ No ☐

Have you ever had x-rays taken?

Area of body:	When?	Where?

Do you wear orthotics or heel lifts? Yes ☐ No ☐

Current Medicines and Supplements

Please list any medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription)

_____

_____

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

_____

***Is there anything else which may help to better understand you which have not been discussed?

_____

_____

_____

_____

Why are you here at this point in time?

_____

_____

_____

_____

____ I consent to a professional and complete chiropractic/ medical examination and to any radiographic/diagnostic examination that the doctor deems necessary.
I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Print Patient Name: _____ Date: _____

Signature: _____

Patient Name:_____

*****Diet

Please circle any dietary selection that is appropriate for you, and grade according to the following scale:

D - Consume this daily | **FD** - Consume this a few times per day | **W** - Consume this weekly | **FW** - Consume this a few times per week
FM - Consume a few times per month (less than weekly) | **M** - Consume this monthly | **O** - Do not consume this

Alcohol	Eggs	Fasting	Artificial Sweetener
Tobacco	Fruit	Diet food	Weight Control Diet
Coffee	Beef	Refined Sugar	Raw Vegetables
Soda	Poultry	Fish	Whole Grains
Fried Foods	Organic foods	Seafood	Dairy
Cooked or canned vegetables			

The type of diet I usually follow is classified as: _____

Past Health History

Please mark the following conditions you may have had or have now (- have had + have now):

☐ Alcoholism	☐ Allergy	☐ Anemia	☐ Arteriosclerosis	☐ Arthritis	☐ Asthma
☐ Back Pain	☐ Cancer	☐ Cold Sores	☐ Constipation	☐ Convulsions	☐ Depression
☐ Diabetes	☐ Diarrhea	☐ Eczema	☐ Emphysema	☐ Epilepsy	☐ Gall Bladder Problems
☐ Gout	☐ Headaches	☐ Heart Attack	☐ Heart Disease	☐ High Blood Pressure	☐ HIV (Aids)
☐ Irregular Periods	☐ Low Blood Sugar	☐ Malaria	☐ Measles	☐ Menstrual Cramps	☐ Migraines
☐ Miscarriage	☐Multiple Sclerosis	☐Mumps	☐ Neck Pain	☐ Nervousness	☐ Neuritis
☐ Pleurisy	☐ Pneumonia	☐ Polio	☐ Rheumatic Fever	☐ Ringing in ears	☐Sinus Problems
☐ Stroke	☐ Thyroid Problems	☐Tuberculosis	☐ Ulcers	☐ Venereal Disease	☐ Whooping Cough

Other (please explain) _____
_____

****Stressors (Highlight) Helps Dr. Please Fill Out

Because accumulation of stress affects our health and ability to heal please list your top three stresses (you have ever had) in each category:

1. Physical stress (falls, accidents, work postures, etc.)
   a. _____
   _____
   b. _____
   _____
   c. _____

Patient Name: _____

2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)

a. _____

b. _____

c. _____

Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)

d. _____

e. _____

f. _____

On a scale of 1-10 please grade your present levels of stress (including physical, bio-chemical and psychological or mental/emotional):

At work:	At home:	At play:

On a scale of 1-10, (1 being very poor and 10 being excellent) please describe you're:

Eating habits:	Exercise habits:	Sleep:	General health:	Mind set:

How do you grade your physical health?

Excellent ☐	Good ☐	Fair ☐	Poor ☐	Getting better ☐	Getting worse ☐

How do you grade your emotional/mental health?

Excellent ☐	Good ☐	Fair ☐	Poor ☐	Getting better ☐	Getting worse ☐

***Is there anything else which may help to better understand you which has not been discussed?

_____

_____

_____

_____

Why are you here at this point in time?

_____

_____

_____

____ I consent to a professional and complete chiropractic/ medical examination and to any radiographic/diagnostic examination that the doctor deems necessary.
I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Print Patient Name: _____ Date: _____

Signature: _____

REVIEW OF SYSTEMS

Patient's Name_____ Date_____
Treating Physican_____ DOB_____

Please check the appropriate "yes" or "no" responses to the following questions. If the answer is "yes", please identify if this is a problem that you currently have.)

		Yes	No	Current	Explain
Constitution:	Sudden weight loss or gain?	___	___	___	_____
Eyes:	Changes in vision?	___	___	___	_____
	Watering ?	___	___	___	_____
	Pain or pressure?	___	___	___	_____
Ears, Nose, Mouth, Throat:	Changes in hearing?	___	___	___	_____
	Blood nose?	___	___	___	_____
	Blisters in mouth?	___	___	___	_____
	Throat pain?	___	___	___	_____
Cardio-vascular:	Chest pain?	___	___	___	_____
	Palpitations?	___	___	___	_____
	Ankle swelling?	___	___	___	_____
Respiratory:	Difficulty breathing?	___	___	___	_____
	Coughing?	___	___	___	_____
Gastro-intestinal:	Abdominal pain?	___	___	___	_____
	Blood in stool?	___	___	___	_____
Genito-urinary:	Frequent urination?	___	___	___	_____
	Blood in urine?	___	___	___	_____
	Painful urination?	___	___	___	_____
Musculo-skeletal:	Joint pain?	___	___	___	_____
	Muscle pain?	___	___	___	_____
Neurologic:	Headaches?	___	___	___	_____
	Numbness, Tingling?	___	___	___	_____
Hematologic/ Lymphatic:	Swollen glands?	___	___	___	_____
	Bleeding problems?	___	___	___	_____
Endocrine:	Increase thirst?	___	___	___	_____
	Changes in temperature?	___	___	___	_____
Skin:	Rashes?	___	___	___	_____
	Itching?	___	___	___	_____
Allergic/ Immunologic:	Allergies?	___	___	___	_____
	Immune disorders?	___	___	___	_____

PAST, FAMILY, SOCIAL HISTORY

Patient's Name_____ Date_____

Treating Physician_____

PAST MEDICAL HISTORY

(Please check the appropriate "yes" or "no" responses to the following questions. If the answer is "yes", please explain in the space provided. If more space is required, please use opposite side of page.)

	Yes	No	Explain
1. Any history of heart, lung, bowel or urinary problems?	___	___	_____
2. Any history of diabetes?	___	___	_____
3. Any history of high blood pressure?	___	___	_____
4. Any history of accidents?	___	___	_____
5. Any history of surgery or operations?	___	___	_____
6. Are you taking any medication?	___	___	_____
7. Any history of cancer?	___	___	_____
8. Have you ever been hospitalized?	___	___	_____

SOCIAL HISTORY

(Please check the appropriate "yes" or "no" responses to the following questions. If the answer is "yes", please explain in the space provided. If more space is required, please use opposite side of page)

1. Have you ever smoked?	___	___	_____
2. Do you smoke now?	___	___	_____
3. Do you drink alcohol?	___	___	_____
4. Are you working?	___	___	_____
5. Are you working part time?	___	___	_____
6. Are you working full time?	___	___	_____
7. Are you married or do you have a significant other?	___	___	_____

FAMILY HISTORY

Section One

(Please check the appropriate "yes" or "no" responses to the following questions. If the answer is "yes", please explain in the space provided. If more space is required, please use opposite side of page.)

1. Any history of diabetes in your family?	___	___	_____
2. Any history of heart disease in your family?	___	___	_____
3. Any history of cancer in your family?	___	___	_____
4. Any history of arthritis in you family?	___	___	_____

Section Two

(Please describe the health status of each of the following family members. If deceased, please list the age and cause of death)

Mother_____

Father_____

Siblings_____

Children_____

Print Patient Name:_____
Date: _____

Informed Consent for Medical / Chiropractic/ Acupuncture/NAET Treatment

Dear Patient,

We encourage and support a shared decision making process between us regarding your health needs. As a part of that process you have a right to be informed about your condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. The information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

Every type of health care is associated with some risk of a potential problem. This includes Medical/Chiropractic/Acupuncture/NAET care. We want you to be informed about potential problems associated with Medical /Chiropractic/Acupuncture/NAET care before consenting to treatment. This is called informed consent.

Chiropractic:
Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily the nervous system) and this relationship can affect the restoration and preservation of health.

Chiropractic adjustments/ joint mobilizations are performed by Chiropractors. It is the moving of bones to correct or reduce spinal and extremity joint subluxations with the doctor's hands or with the use of a mechanical device, following palpation and/or other examination procedures. A Vertebral Subluxation is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and /or does not move properly causing interference and /or irritation to the nervous system. The primary goal of Chiropractic Care is the removal and/or reduction of the nerve interference caused by vertebral subluxation. A Chiropractic examination will be performed which may include spinal and physical examination , orthopedic and neurological testing, palpation, specialized instrumentation, x-rays and laboratory testing. Frequently with spinal or joint adjustments techniques create a "pop" or "click" sound/sensation in the area being treated, such as the noise when a knuckle is "cracked", and you may feel movement of the joint. In addition some ancillary procedures, such as hot and cold packs, electric muscle stimulation, therapeutic ultrasound, massage therapy, paraffin wax, cervical traction, mechanical traction, therapeutic exercises, vibrational –propreceptive rehab and acupuncture/acupressure, laser acupuncture may also be used. In this office, we use trained staff personal to assist the doctor(s) with portions of your consultation, examination, x-ray taking, physical therapy application, traction, massage therapy, exercise instruction, etc. Occasionally when your doctor is unavailable, another clinic doctor under the direction of the primary doctor will treat you on that day.

Possible Risks: As with any heath care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. A minority of patients may notice stiffness or soreness after the first few days of treatment.

Stroke: There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke: rather recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages if a stroke. In essence , there is a stroke already in process. However , you are being informed of this report associated because a stroke may cause serious neurological impairment.

Disc Herniation: Disc herniations that create pressure on the spinal nerve or on the spinal cord are frequently successfully treated by Chiropractors and Chiropractic adjustments/joint mobilizations, traction, etc. This includes both in the neck and in the back. Yet, occasionally chiropractic treatment (adjustments/joint mobilizations, traction, etc.) may aggravate the problem and rarely surgery may become necessary for correction.

Rarely chiropractic adjustment/joint mobilizations may also cause a disc problem if the disc is in a weakened condition. These problems occur so rarely that there are no available statistics to quantify their probability.

Soft Tissue Injury: Soft tissues primarily refer to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely chiropractic adjustments/joint mobilizations, traction, massage therapy, etc., may tear some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long-term effects for the patient. These problems occur so rarely that there are no statistics to quantify their probability.

Rib Fractures: The ribs are found only in the thoracic spine or the middle back. They extend from your back to your front chest area. Rarely a chiropractic adjustment/joint mobilization will crack a rib bone, and this is referred to as a fracture.

This occurs only on patients that have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust/manipulate all patients very carefully, and especially those who have osteoporosis noted on their x-rays. These problems occur so rarely that there are no statistics to quantify their probability.

Physical Therapy Burns: Some of the machines we use generate heat. We also use both heat and ice, and recommend them for home care on occasion. Everyone's skin has different sensitivity to these modalities, and rarely, both heat and ice can burn or irritate the skin. The result is temporary increase in pain, and there may even be some blistering of the skin. These problems occur so rarely that there are no statistics to quantify their probability. Furthermore physiotherapy may include the proceeding as well as a allergic reaction to gels or lotions in some cases.

Soreness: It is common for chiropractic adjustments/joint mobilizations, traction, massage therapy, exercise, etc. to result in a temporary increase in the soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic changes. It is not dangerous, but please tell your doctor about it.

Acupuncture: If using dry needling technique the following risks can occur: infection at site of insertion of needle, bruising, itching, redness, swelling, allergic response to needle.

NAET: Sweating when holding the substance, itching, fatigue after treatment, muscle weakness after treatment.

Probability of risks occurring: There may be other problems or complications that might arise from Chiropractic/Medical/Acupuncture/NAET other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and / or explain them all in advance of treatment. The risks of complications due to chiropractic treatment have been described as "rare', about as often as complications are seen from the taking of a single aspirin tablet. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options, which could be considered, may include the following:

- Over the counter analgesics. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects I a significant number of cases.
- Medical care, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- Hospitalization in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- Surgery in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as 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 induce chronic pain cycles. It is quite probably that delay of treatment will complicate the condition and make future rehabilitation more difficult. The same consequences can occur with patients suffering from allergies, chronic conditions and specific medical problems not listed here.

Chiropractic/ Medical/ Acupuncture/ NAET is a system of health care delivery, and therefore, as with any health care delivery system we cannot promise a cure for any symptoms, disease, or condition as a result of treatment in this center. We will always give you our best care, and if results are not acceptable, we will refer you to another provider whom we feel will assist your situation.

If you have any questions on the above, please ask your doctor. When you have a full understanding, please sign and date below.

1. I, _____, authorize the performance upon myself of the following procedure(s): Examination/ X-rays(gowned if needed) Ultrasound, sinusoidal current, interferential currents, traction, hydrocollator, electrical muscle stimulation, ice therapy, acupuncture, contact reflex analysis with nutritional supplementation, N.A.E.T, and chiropractic manipulative/joint mobilization techniques to be performed by or under the direction of the Doctors and staff of Integrated Medical Center, Inc. d.b.a./Quantum Wellness Center
2. I also consent to the performance of other diagnostic and / or therapeutic procedures in addition to or different from those stated above, whether or not arising from presently unforeseen conditions, that the doctors, associates and / or assistants, may consider necessary or advisable in the course of my health care or treatment.
3. I acknowledge that no guarantee or assurance as to the results that may be obtained from the procedure(s) has been given by the doctors, their associates or assistants.

4. I have read the explanation above of medical / chiropractic/ acupuncture / NAET treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

I, _____ of my own free will choose to become a patient of Drs. Popkin/Grundstein. I understand that some of the techniques and products used in this clinic are neither FDA (Food and Drug Association) approved or considered a "main stream" traditional medicine.

Drs. Popkin/Grundstein can not guarantee the results of these treatments or products.

I am aware that I am free to seek other medical opinions or other care at any time. I am also aware that Drs. Popkin/Grundstein meet the requirements by Florida law.

I hereby exercise my freedom of choice in medicine/chiropractic to follow Drs. Popkin/Grundstein's recommendations or not as I choose.

Signed_____**Witness**_____**Date**_____

Integrated Medical Centers, Inc DBA Quantum Wellness Center
1261 South Pine Island Road Plantation, Florida 33324

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

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

Our Legal Duty

We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information. We must abide by the terms of this Notice while it is in effect. However, we reserve the right to change the terms of this Notice and to make the new notice provisions effective for all of the protected health information that we maintain. If we make a change in the terms of this Notice, we will notify you in writing and provide you with a paper copy of the new Notice, upon request.

Uses and Disclosures

There are a number of **situations in which we may use or disclose** to other persons or entities your confidential health information
Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices
These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or nder emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment. *Example:* We may use your health information within our office to provide health care services to you or we may disclose your health information to another provider if it is necessary to refer you to them for services.

Payment. *Example:* We may disclose your health information to a third party such as an insurance carrier, an HMO, a PPO, or your employer, in order to obtain payment for services provided to you.

Health Care Operations. *Example:* We may use your health information to conduct internal quality assessment and improvement activities and for business management and general administrative activities.

Appointment Reminders. *Example:* Your name, address and phone number and health care records may be used to contact you regarding appointment reminders (such as voicemail messages, postcards or letters), information about alternatives to your present care, or other health related information that may be of interest to you.

In the following cases we never share your information unless you give us written permission: Marketing purposes, sale of your information, most sharing of psychotherapy notes. In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your Acknowledgement or Authorization**:

Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. You should be aware that we utilize an "open adjusting room" in which several people may be adjusted at the same time and in close proximity. We will try to speak quietly to you in a manner reasonably calculated to avoid disclosing your health information to others; however, complete privacy may not be possible in this setting. If you would prefer to be adjusted in a private room, please let us know and we will do our best to accommodate your wishes.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

EXCEPT AS INDICATED ABOVE, YOUR HEALTH INFORMATION WILL NOT BE USED OR DISCLOSED TO ANY OTHER PERSON OR ENTITY WITHOUT YOUR SPECIFIC AUTHORIZATION, WHICH MAY BE REVOKED AT ANY TIME. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization.

Patient Rights

Right to Request Restrictions. You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction. Your request must be made in writing to our Privacy Official. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Right to Receive Confidential Communications. You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled. Your request to receive confidential communications must be made in writing to our Privacy Official.

Right to Inspect and/or Copy. You have the right to inspect, copy and request amendments to your health records including electronic health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information. Your request to inspect and/or copy your health information must be made in writing to our Privacy Official.

Right to Amend. You have the right to request that we amend certain health information for as long as that information remains in your record. Your request to amend your health information must be made in writing to our Privacy Official and you must provide a reason to support the requested amendment.

Right to Receive an Accounting. You have the right to inspect, copy and request amendments to you health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information. Your request to receive an accounting must be made in writing to our Privacy Official.

Right to Receive Notice. You have the right to receive a paper copy of this Notice, upon request. We are obligated to notify you if there is a breach of your PHI unless there is a low probability of PHI compromise.

Complaints

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint.

All questions concerning this Notice or requests made pursuant to it should be addressed to: Privacy Officer, *Integrated Medical Centers, Inc DBA Quantum Wellness Center*
1261 South Pine Island Road Plantation, Florida 33324

I do hereby acknowledge receipt of a copy of the Notice of Privacy Practices, Policies, and Procedures.

Patient Name	Patient Signature	Date

Name of Personal Representative	Signature of Personal Representative	Date

Legal Authority of Personal Representative

Integrated Medical Centers, Inc DBA Quantum Wellness Center
1261 South Pine Island Road Plantation, Florida 33324

954-370-1900 (o)
954-476-6281(f)

HEALTH CARE AUTHORIZATION FORM

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my treatment, payment of my bills or in the performance of health care operations of this chiropractic office. A copy of our notice is attached and we encourage you to read it and request your own copy if you would like one.

This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to _____ Integrated Medical Centers, Inc./ DBA Quantum Wellness Center to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS:

- I give permission to ____ to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information.

- If ____ contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.

- I give permission to ____ to use my name on a welcome board, referral board, and birthday board.

- I give permission to ____ to use my photograph on their patient picture bulletin board and other marketing materials such as their brochure, website and ads in print media.

- I give permission to ____ to use any testimonial written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochure, on their website or in ads in print media.

- I give ____ permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with doctor at any time in private, the doctor will provide a room for these conversations.

- By signing this form you are giving ____ permission to use and disclose your protected health information in accordance with the directives listed above.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. This authorization will remain in effect for the duration of my care at _____ Integrated Medical Centers, Inc./ DBA Quantum Wellness Center plus 7 years or until revoked by me.

(over)

RIGHT TO REVOKE AUTHORIZATION:
You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of ____. The written notice must contain the following information:

Your name, Social Security number and date of birth;
A clear statement of your intent to revoke this AUTHORIZATION;
The date of your request; and
Your signature.

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by ____ for its own use/disclosure of PHI. *(Minimum necessary standards apply.)*

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, ____ will not refuse to provide treatment however, it will not be possible for ____ to file third party billing on my behalf and I will be responsible for 1)payment in full at the time services are provided to me 2) scheduling my own appointments since ____ will be unable to contact me 3) all contact with ____ regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.*

I have the right to inspect or copy, within boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

HEALTHCARE AUTHORIZATION

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

SSN:_____ DOB:_____

Patient's name (please print): _____

Patient's Signature: _____

Today's Date: _____

Name of Personal Representative (if someone is designated to act on your behalf/or for a minor)

Parent or Personal Representative name (please print):_____

Signature:_____

Description of Representative's Authority to Act on Patient's Behalf:_____

_____

ACETYLCHOLINE QUIZ	BEFORE	AFTER
I find myself writing things down so I won't forget them.		
I find it hard to do math in my head.		
I have a hard time finding words or remembering what I was saying if interrupted during a conversation.		
I get nervous or anxious when I have to learn something new, like new software at work.		
When reading a book or watching a movie, I find it harder to follow the plot than it used to be.		
I misplace my keys, wallet, or glasses frequently.		
I have trouble focusing during long conversations or meetings.		
I feel like my brain is just not functioning at its peak.		
DOPAMINE QUIZ		
I feel down a lot and don't have the energy or desire to do anything.		
I am a low-energy kind of person, mentally or physically.		
I struggle to get motivated to exercise.		
I have trouble concentrating or focusing on things.		
I tend to sleep a lot or have trouble waking up.		
I use substances to "wakeup" such as caffeine, chocolate, diet pills, or even cocaine.		
GABA QUIZ		
It is hard for me to relax and kick back.		
I am easily stressed out or overwhelmed.		
It is common for me to feel overworked or pressured.		
My body is stiff or uptight.		
I sometimes feel weak and shaky.		
I am bothered by loud noises, lights or too much activity.		
I feel more anxious or stressed if I skip meals.		
I use substances to help me relax, such as sugar, alcohol, and/or drugs.		

Patient name: _____

Serotonin Quiz		
My head is full of ANTs (automatic negative thoughts).		
I am a glass-half-empty person.		
I have a low self-esteem and low self-confidence.		
I tend to have obsessive thoughts and behaviors (such as being a perfectionist or neat freak).		
I get the winter blues or have a family history of SAD (seasonal affective disorder).		
I tend to be irritable, easily angered, and/or impatient.		
I am shy and afraid of going out or have a fear of heights, crowds, flying, and/or speaking in public.		
I feel anxious or have panic attacks.		
I have PMS (premenstrual syndrome) with moodiness, cravings, breast tenderness, and bloating before my period.		
I have trouble falling asleep.		
I wake up in the middle of the night and have trouble getting back to sleep or wake up too early in the morning.		
I crave sweets or starchy carbs like bread and pasta.		
I feel better when I exercise.		
I have muscle aches, and/or jaw pain, and/or a family history of fibromyalgia.		
I have a family history of treatment with SSRIs (serotonin boosting antidepressants).		

Patient name: _____

Informed Consent Regarding Nutritional and Herbal Supplements

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201(g)(1), the term *drug* is defined as an "article intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease." Technically, vitamins, minerals, trace elements, amino acids, herbs, or homeopathic remedies are not classified as drugs. However, these substances can have significant effects on physiology and must be used rationally. In this office, we provide nutritional counseling and make individualized recommendations regarding use of these substances in order to upgrade the quality of foods in a patient's diet and to supply nutrition to support the physiological and biomechanical processes of the human body. Although these products may also be suggested with a specific therapeutic purpose in mind, their use is chiefly designed to support given aspects of metabolic function. Use of nutritional supplements may be safely recommended for patients already using pharmaceutical medications (drugs), but some potentially harmful interactions may occur. For this reason, it is important to keep all of your healthcare providers fully informed about all medications and nutritional supplements, herbs, or hormones you may be taking.

Sale of Nutritional Supplements at Quantum Wellness Center

You are under no obligation to purchase nutritional supplements at our clinic.

As a service to you, we make nutritional supplements available in our office. We purchase these products only from manufacturers who have gained our confidence through considerable research and experience. We determine quality by considering: (1) the quality of science behind the product; (2) the quality of the ingredients themselves; (3) the quality of the manufacturing process; and (4) the synergism among product components. The brands of supplements that we carry in our facility are those that meet our high standards and tend to produce predictable results.

While these supplements may come at a higher financial cost than those found on the shelves of pharmacies or health food stores, the value must also include assurance of their purity, quality, bioavailability (ability to be properly absorbed and utilized by the body), and effectiveness. The chief reason we make these products available is to ensure quality. You are not guaranteed the same level of quality when you purchase your supplements from the general marketplace. We are not suggesting that such products have no value; however, given the lack of stringent testing requirements for dietary supplements, product quality varies widely.

If you have concerns about this issue, please discuss them with our staff.

I, _____,

have read and understand the above statement on _____ (date),

witnessed by _____, _____ (date).