Welcome to Awaken Life Family Chiropractic, LLC

Please review the practice information and policies below.

People today juggle an incredible number of responsibilities: jobs, children, friendships, relationships, errands, appointments - the list is endless! You've got to be healthy just to keep up! We are pleased to welcome you to Awaken Life Family Chiropractic, LLC, and are thankful you have chosen us to partner with you in restoring and maintaining optimal health.

The Clinic

Awaken Life Family Chiropractic, LLC specializes in pregnancy, pediatric, and family wellness chiropractic care. We also offer nutritional advice, Graston (myofascial therapy), extremity adjusting and craniosacral/body balancing therapies. Care is provided by Dr. Emily Ceci, DC (owner). She is licensed by the WI Chiropractic Examining Board. She has additional training through the International Pediatric Chiropractic Association (ICPA) for those protocols and techniques specific to pregnant and pediatric populations, including Webster technique. *She is available, on-call, for home, hospital, or birth center visits ~ ask for details!*

Appointments/Scheduling

Appointments can be made online via the website: www.awakenlifefamilychiro.com. If online scheduling doesn't work for you, you may also call or schedule via email. **If the visit is for someone other than you, please indicate who intend to receive care in the comment section.**

Payment

Payment is due at the time of service. Awaken Life Family Chiropractic accepts cash, checks, credit card and Health Savings Account (HSA) cards. Our new client fee is $75.00. If additional family members schedule as a new patient within 30 days their new client fee is $40.00. **Emergency visits outside of office hours or off location (home or labor visits) will be charged at the rate of $150 per visit within a 20 mile radius. Standard mileage fees outside 20 mile radius will be charged.**

Cancellation Policy

As a courtesy to all of our patients, we strive to maintain a smooth and efficient operation so that you can enjoy your treatment on time, all of the time. Since our services are by appointment only, please make yourself familiar with our cancellation policy.

- 24 hour notice is **required** for cancelling or rescheduling an appointment to avoid charges.
- **A no call/no show will result in a $25.00 charge, including new patients.**
- Emergencies and certain exceptions (labor and delivery) can be made on a case by case basis, but must be done by phone **before** the appointment.
- A no show/no call charge must be paid before another appointment will be scheduled or administered.

We greatly appreciate your business and thank you deeply for your cooperation with this policy.

HIPAA

The Health Insurance Probability & Accountability Act (HIPAA) of 1996 is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, the right to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared an explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your information. Awaken Life Family Chiropractic's HIPAA privacy policies are available to read and print on our website. Please ask if you would like a copy to read upon your visit to our clinic.

Please date, sign and print your name below to acknowledge that you have read and understand Awaken Life Family Chiropractic's Practice Information, Cancellation Policy, and Notice of Privacy Practices.

_____ _____

Print Name Signature

_____ _____

Today's Date Relationship to patient (if applicable)

CHIROPRACTIC INFORMED CONSENT TO TREAT

We believe that our patients should be active participants in their care. Please feel free to ask any questions about your treatment so that you may continue to make informed, responsible decisions regarding your health care. In addition, we encourage all of our patients to discuss their treatment with their primary care physician. Just as the body works as an integral whole, so must the people who help you to care for it.

_____ (initial) We do not offer to diagnose or treat any disease or condition other than vertebral subluxation (spinal misalignment). However, if during the course of 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 provider who specializes in that area.

_____ (initial) You have the right to be informed about your condition and the recommended procedure(s) to be used so that you can make an informed decision whether or not to undergo the procedure after knowing the risks and hazard involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure. Doctors of Chiropractic, Medical Doctors and Physical Therapists using manual therapy treatment in the cervical spine (neck) are required to explain that there have been rare cases of injury to a vertebral artery as a result of treatment. Such an injury has been known to cause a stroke, sometimes with serious neurological damage. The rare chance of this happening is estimated to be approximately from 1 per 400,000 treatments to 1 per 10 million treatments. Appropriate tests will be performed to help identify if you may be susceptible to this type of injury; you will be notified if that is the case. If you have any questions about this, please do not hesitate to speak with your practitioner. As with any health procedure, complications may arise during treatment. These complications include soreness, muscle/ligament strain, dislocations, fractures, or disk injuries. These are *extremely* rare occurrences.

_____ (initial) I hereby request and authorize the performance of diagnostic tests, procedures and treatment deemed necessary by personnel involved in my care. I consent to the performance of chiropractic adjustments and other procedures within the scope of chiropractic practice within the State of Minnesota on me (or on the patient named below, for whom I am legally responsible) by the chiropractor(s) named below and/or other licensed chiropractor who now or in the future treat me while employed by, working or associated with or serving as back-up for the chiropractor named below, whether signatories to this form or not.

_____ (initial) I understand that methods of treatment may include, but are not limited to chiropractic adjustments, craniosacral therapy, kinesio-taping/Rock-Tape, Graston/myofascial/trigger point therapy, herbal medicine and nutritional counseling. The nutritional supplements, essential oils, or homeopathic remedies that have been recommended are traditionally considered safe. Supplements may have side effects including, but not limited to, gastrointestinal disturbances, headache, and rashes. I will notify my practitioner of any side effects associated with the consumption of the recommended supplements.

_____ (initial) I do not expect my provider to be able to anticipate and explain all possible risk and complications of the treatment, and I wish to rely on my provider to exercise judgment during the course of treatment. I understand that results are not guaranteed.

_____ (initial) I understand that it is my responsibility to inform my practitioner if I am pregnant or believe I may be pregnant.

Authorization to Treat a Minor (under the age of 18)

I hereby request and authorize my doctor at this clinic to perform diagnostic tests and render chiropractic adjustment and other treatment to my minor son/daughter. As of this date, I have legal right to select and authorize health care services for the minor child named above. Under the terms and conditions of my divorce (if applicable), separation or other authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in anyway, I will immediately notify Awaken Life Family Chiropractic.

By signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of chiropractic adjustments and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Print Name _____ Signature _____

Date _____ Relationship to patient (if applicable)_____

Awaken Life Family Chiropractic, LLC
• Dr. Emily Ceci, DC •
530 North 108th Place, Wauwatosa, WI 53266
920.284.8835 • www.awakenlifefamilychiro.com