BLAINE FAMILY CHIROPRACTIC

New Patient Intake Form

Name: _____

Date of Birth: Month _____ Day _____Year _____

Address: _____

_____

Telephone: Cell _____Home _____

Email Address: _____

Appointment Reminders by: □ Text □ Email □ Phone – (Circle): Cell/Home

In case of an emergency, whom may we contact? Name: _____

Relation: _____ Phone: _____

Please list any surgeries: _____

_____

Please list any medications/hormone/supplement you are taking now and respective doses:

_____

_____

Are you currently under any medical care for any reason? If yes, please explain:

_____

What goals are you hoping to achieve from cryotherapy? _____

_____

Please check if you suffer from any of the following conditions listed below

High Blood Pressure:_____	Kidney Disease:_____	Joint or muscle injuries:_____
Stroke:_____	Migraines:___	Areas of Chronic Pain:_____
Joint Disease:_____	Tension Headaches:_____	Skin Disease:_____
Respiratory Diseases:_____	Heart Disease:_____	Digestive Disease:___
Areas of Numbness:_____	Diabetes:_____	Infectious Disease:___
Paralysis:____		

Waiver of Liability and Hold Harmless Agreement

1. In consideration for using the cryo device (equipment), I hereby release, waive, discharge, and hold harmless, Blaine Family Chiropractic (BFC), its officers, servants, agents, employees and volunteers (hereinafter referred to as releases) from any and all liability, claims, demands, actions and causes of action whatsoever arising out of or related to any loss, damage, or injury, that may be sustained by any person, while using the equipment or due to the use of the equipment.
2. I hereby confirm that no warranty or guarantee, or other assurance, has been made tome covering the results of the cryo process, and I hereby relieve them and hold them harmless from all liabilities for injury or damage that may occur to me, I fully understand the administration of the process, including possible adverse reactions, side effects, or other possible complications. It is understood that this consent is being given in advance of any administration of the process and is given by me voluntarily to use the equipment.
3. I am fully aware of the risks and hazards connected with the equipment, including the risk of physical injury or disability as the result of such injury, and I am voluntarily participating in said equipment usage, and entering the above-named premises to engage in such usage. I voluntarily assume full responsibility for any risks of loss, property damage or personal injury that may be sustained, or loss or damage to property as a result of being engaged in such an activity.
4. I further hereby agree to indemnify and hold harmless the releasees from any loss, liability, damage or cost that may incur due to the use of the equipment by me.
5. It is my express intent that this release and hold harmless agreement shall bind the members of my family and spouse (if any), if I am alive, and my heirs, assignees and personal representative, if I am not alive, and shall be deemed as a release, waiver, and discharge of the above named releasees. I hereby further agree that this waiver of liability and hold harmless agreement shall be construed in accordance with the laws of the state of Minnesota.
6. I understand that the releasees will not be responsible for any medical costs associated with any injury.
7. I understand that whole body cryotherapy, cryo-facial, localized cryotherapy, cryo-fat freezing therapy, and infrared sauna is provided for the basic purpose of relaxation, stress reduction, relief of muscular tension, recovery from muscular tension, and recovery from surgery illness, or injury. I further understand that all cryotherapies should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment that I am aware of.
8. I understand that cryotherapy therapists (with exception of Dr. Aaron Frach D.C. and Dr. Kiaja Undersander D.C.) are not qualified to perform skeletal adjustments, diagnose and /or prescribe, and that nothing said in the course of the session should be construed as such.
9. Because cryotherapies are contraindicated under certain conditions, I affirm that I have all known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I forget to do so.

My signature below constitutes my knowledge that (1) I have read, understand, and fully agree to the foregoing consent, (2) the proposed indoor cryo process has been satisfactorily explained to me and I have all of the information I desire and (3) I hereby give my authorization and consent. This consent shall stand as long as I use the equipment at the location now and in the future.

I have read the instructions for proper use of the facilities and do so at the risk and hereby release the owners, operators, franchisers, or manufacturers, from any damage or harm that I might incur due to use of the facilities. In signing this release, I am at least (18) years of age and fully competent; I have given up considerable future legal rights; and I execute this release freely, voluntarily, and under no duress or threat of duress, without inducement, promise or guarantee being communicated to me.

Furthermore, I agree that I will comply with all instructions on the use of the cryo devices and that I am using these services at my own risk.

Participants Printed Name	Participants Signature	Date

Printed Name of Parent or Legal Guardian	Signature of Parent or Legal Guardian

NOTICE OF HIPAA PRIVACY PRACTICE

Blaine Family Chiropractic (BFC) is required by law to notify you in writing that we must maintain the privacy and confidentiality of your Personal Health Information (PHI). In addition, we must provide you with written notice concerning your rights to gain access to your health information and the potential circumstances under which by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Once you have read this notice, please sign this page, and return to the front desk receptionist.

PERMITTED DISCLOSURES:

1. Treatment purposes – discussion with other health care providers involved in your care.
2. Inadvertent disclosures – our open treating area can be overheard. If you need to speak privately to the doctor please let our staff know so we can place you in a private consultation room.
3. For payment purposes – to obtain payment from your insurance company or any available collateral source.
4. For workers compensation purposes – to process a claim or aid in investigation.
5. Emergency – in the event of a medical emergency we may notify a family member.
6. For public health and safety – in order to prevent or lessen a serious or imminent threat to the health or safety of a person or the general public.
7. To government agencies or law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefit purposes.
9. Deceased persons – discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders – we may call your home and leave messages regarding a missed appointment or apprise you of changes in practice hours or upcoming events.
11. Spouses, household partners and other close family members.
12. Change of ownership – in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address that is different from your registered address.
4. To request restrictions on certain uses and disclosures and to whom we release information.
5. To inspect your records and receive a copy of your records at no charge, with advanced notice.
6. To request amendments to information, however like restrictions we are not required to agree to them.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information please call BFC at 763.786.5585.

Note: This office reserves the right to amend this notice of privacy practice at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I have received a copy of Blaine Family Chiropractic Patient Privacy Notice and understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding to the doctor. I understand that a more comprehensive version of this "Notice" is available to me upon request.
At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____

Patient Signature Date

_____ _____

Witness Date