vitality
CHIROPRACTIC

WELCOME!

Thank you for choosing Vitality! Are you ready for a healing approach like you've never experienced before? Our custom Chiropractic sessions will help guide you to discover the amazing wellness potential within you.

Our Healing and Wellness Approach

Healing and wellness are processes, not events, and we are not a "quick fix" practice. We strive to build a relationship with you as we assist you in achieving your overall health and wellness goals. Our holistic approach transforms your physical body's alignment and spirit to help achieve better balance.

Your Chiropractic Sessions:

Your experience starts with a pain control therapy or a fully customizable HydroMassage that gives you powerful, heated, deep-tissue relaxation. You will then receive your Chiropractic Adjustment using light touch and gentle instruments. We also incorporate Lifestyle Coaching and all the TLC that makes Vitality unique. Your sessions are never procedures done to you, but instead are creative healing experiences with you.

Payment & Insurance: You will be required to pay for your sessions at the time they are rendered. The new patient exam is $85 and the session fee is $75. If your insurance company covers chiropractic care it is possible you may receive some reimbursement. We will assist you with that process by printing you a "Superbill," that you send in. Vitality is not a participating provider for any insurance company.

Initial _____

Diagnosis: We do not diagnose or treat any symptom, disease, or condition. If you have questions about naming or treating symptoms, we encourage you to consult with a medical doctor. It is important to understand that we do not imply that any particular session or series of sessions will "cure" any symptom, disease, or condition.

Initial _____

HydroMassage: Anyone experiencing one or more of the following conditions, or have a condition that heat or massage would have an adverse effect should get physician approval prior to use: Heart or circulatory problems, inflammatory conditions such as phlebitis, varicose veins or thrombosis, swollen joints, acute inflammations, severe bruising, skin infections, contagious diseases, a high temperature, pain radiating to the arms or legs when the back is massaged, any other conditions in which heat or massage would be harmful. Please use caution after use of HydroMassage equipment. Some users report sensations of dizziness or lightheadedness following their HydroMassage session. I acknowledge that I have read the above contraindications, and that my use of the HydroMassage equipment is completely voluntary. I hold JTL Enterprises Inc. / HydroMassage, and Vitality Chiropractic completely harmless for any injury resulting from the use of the HydroMassage equipment.

Initial _____

24 Hour Scheduling Policy: Missed, Late or Rescheduled appointments, unless emergency or weather related, must be within a 24-hour notice period, or you will be subject to a $25 fee.

Initial _____

_____

Signature Date

DATE / /

NAME AGE DOB / /

ADDRESS

CITY STATE ZIP

CONTACT NUMBERS M( ) HM( ) WK( )

EMAIL SSN - -

Who may we thank for referring you to Vitality?

ASSESSMENTS

The following sections will assess where you are from a holistic approach, to determine your baseline. Section 1 outlines your overall physical assessment. Section 2 gives you space to address specific health issue(s), Section 3 overviews your body-mind-spirit states, and Section 4 provides us with information about your personal goals and expectations.

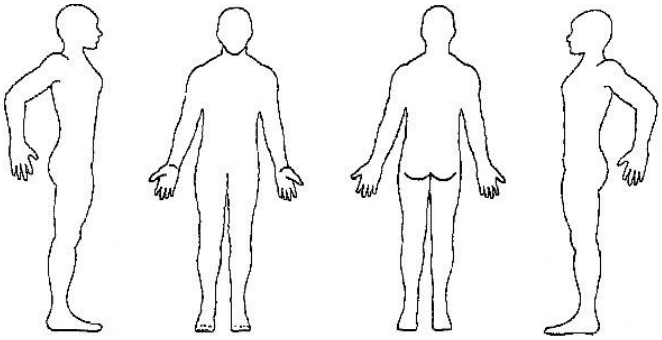
Section 1: Physical Assessment: Please (x) if you are experiencing any conditions Currently(C) and/or in the Past(P)

Condition(s)	C	P	Condition(s)	C	P	Condition(s)	C	P
Vehicle Accident (s)			Numb/Tingly Leg			Poor Sleep		
Major Slips/Falls			Numb/Tingly Arm			Heart Disease		
Sports Participation			Irregular Menses			Constipation		
Neck Pain/Stiffness			Urinary Problems			Heartburn		
Sit/Stand long hours			Loss of Balance			Upset Stomach		
Repetitive Motions			Loss of Smell/Taste			Hot Flashes		
Surgery (s)			Ringing in Ears			Chest Pain		
Broken Bone (s)			High Blood Pressure			Headache/ Migraine		
Back Pain			Fainting			Dizziness		
Diarrhea			Allergies			Fatigue		
Cold Hands			Cold Feet			Cancer		

List any other issues and/or comment on any of the above: (ex, Dates/type of surgeries, accidents, what allergic to, etc.)

List any medications, vitamins, supplements, etc. and why you use them:

Section 2: Specific Health Issue: If you have more than one health issue to address, please print a separate page for each issue.

PLEASE FILL IN WITH DETAIL	FOR OFFICE USE ONLY
What is the health issue?	
When did it start?_____/_____/_____ M D YYYY Is this the first time you've experienced it? If no, when?	
What do you do that makes it feel better?	
What do you do that makes it feel worse?	
Are you feeling any sensations? ☐Sharp ☐Dull ☐Numb ☐Tingling ☐Stabbing ☐Tightness ☐Other _____	
Rate your pain on a 1-10 scale. '0' is no pain: /10	
Are you experiencing anything radiating? (circle) Right arm Right leg Left arm Left leg Other: _____	
Where on your body are you experiencing your issue? (circle)  Right Front Back Left	
Describe your issue: ☐ Staying Same ☐ Getting Better ☐ Getting Worse	
How often are you experiencing this health issue? ☐ Intermittently (0-25%) ☐ Occasionally (26-50%) ☐ Frequently (51-75%) ☐ Constantly (76-100%)	
Does your issue interfere with any of the following? ☐ Sleep ☐ Walking ☐ Sitting ☐ Standing ☐ Playing	
List any other solutions and/or practitioners utilized for this issue:	
Height:____' ____" Weight: _____lbs. Shoe size: _____	

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Section 3: Body-Mind-Spirit State

BODY STATE	4	3	2	1	0	FOR OFFICE USE ONLY
Do you eat healthy and/or organic foods?	NEVER	RARELY	SOMETIMES	MOSTLY	ALWAYS	
Do you drink water? How much? _____	NEVER	RARELY	SOMETIMES	MOSTLY	ALWAYS	
Do you exercise? How consistently?_____	NEVER	RARELY	SOMETIMES	MOSTLY	ALWAYS	
Do you stretch? How consistently?_____	NEVER	RARELY	SOMETIMES	MOSTLY	ALWAYS	
Do you receive massage or body work? How consistently?_____	NEVER	RARELY	SOMETIMES	MOSTLY	ALWAYS	
Do you detox and/or cleanse? How consistently?_____	NEVER	RARELY	SOMETIMES	MOSTLY	ALWAYS	
Do you listen to and understand your body signals?	NEVER	RARELY	SOMETIMES	MOSTLY	ALWAYS	
					BODY _____ /28	
MIND STATE	**4**	**3**	**2**	**1**	**0**	**FOR OFFICE USE ONLY**
Are you mindful of yourself? (respect, listen & love self)	NEVER	RARELY	SOMETIMES	MOSTLY	ALWAYS	
Do you allow time for yourself? (playtime, downtime, self-care etc.)	NEVER	RARELY	SOMETIMES	MOSTLY	ALWAYS	
Do you use positive self talk?	NEVER	RARELY	SOMETIMES	MOSTLY	ALWAYS	
Do you have a clear, centered and relaxed mind before you sleep?	NEVER	RARELY	SOMETIMES	MOSTLY	ALWAYS	
Do you process and feel balanced in your emotions?	NEVER	RARELY	SOMETIMES	MOSTLY	ALWAYS	
Do you listen to your instincts?	NEVER	RARELY	SOMETIMES	MOSTLY	ALWAYS	
					MIND _____/24	
SPIRIT STATE	**4**	**3**	**2**	**1**	**0**	**FOR OFFICE USE ONLY**
Do you breathe or meditate?	NEVER	RARELY	SOMETIMES	MOSTLY	ALWAYS	
Do you take time to connect with nature and/or animals?	NEVER	RARELY	SOMETIMES	MOSTLY	ALWAYS	
Do you take time to connect with other humans?	NEVER	RARELY	SOMETIMES	MOSTLY	ALWAYS	
Do you feel in control of your life?	NEVER	RARELY	SOMETIMES	MOSTLY	ALWAYS	
Do you take time to relax?	NEVER	RARELY	SOMETIMES	MOSTLY	ALWAYS	
					SPIRIT _____/20	
					BODY-MIND-SPIRIT TOTAL _____/72	

Section 4: About Your Expectations:

ABOUT YOU	FOR OFFICE USE ONLY
What is your occupation or life work?	
Do you enjoy where you live and why?	
Do you have a family or social life that brings you joy?	
What recreational activities do you do?	
What do you love about your life?	
Where are you resisting in your life?	
EXPECTATIONS	**FOR OFFICE USE ONLY**
Why did you choose Vitality?	
What would your short-term expectations look or feel like for you?	
What would your long-term expectations look or feel like for you?	
Do you have any questions on our Chiropractic approach? (HydroMassage, Chiropractic Care, and/or Lifestyle Coaching)	
Do you have any other lifestyle goals?	
Is there anything else you would like Vitality to know about you?	

If you are ready to work together to discover the amazing wellness potential within you…
then you are in the right place! I look forward to connecting with you! ~ Dr. Kent Sifford

Notice of Privacy Practices (HIPAA)

This notice describes how chiropractic and personal information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Uses and Disclosures: Here are some examples of how we might use or disclose your health care information:

Dr. Sifford or a Vitality Chiro+Energy staff member may have to disclose your health information including all of your clinical records to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.

Vitality Chiro+Energy may have to disclose your examination and adjustment records and your payment records to another party, such as an HMO, a PPO, or your employer, if they are potentially responsible for the payment of your services.

Vitality Chiro+Energy may need to use your health information, examination, and adjustment records and your payment records for quality control purposes or for other administrative purposes to efficiently and effectively run our practice.

Our Privacy Pledge: We respect your privacy. Other than disclosures mentioned above, we will not sell your health information.

Permitted Uses and Disclosures without your consent or authorization: Under Federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances. All other circumstances of using your health information require your written consent.

We are permitted to use or disclose your health information if we are providing health care services to you based on the orders of another health care provider. We are permitted to use or disclose your health information if we provide health care services to you as an inmate.

We are permitted to use or disclose your health information if we provide health care services to you in an emergency.

We are permitted to use or disclose your health information if we are required by law to treat you and we are unable to obtain your consent after attempting to do so.

We are permitted to use or disclose your health information if there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

Your right to revoke your authorization: You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

If we have already released your health information before we receive your request to revoke your authorization. I 64.508 (b)(5)(i)

If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. If you wish to revoke your authorization, please write to us at: Vitality Chiro+Energy, 750 Sheridan Lake Rd., Rapid City, SD 57702

Your right to limit uses or disclosures: If there are health care providers, hospitals, employers, insurers or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing, what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree to your re- strictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from anoth- er health care provider.

Your right to receive confidential communication regarding your health information: We normally provide information about your health to you in person at the time your receive chiropractic services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services that we provide at a place other than your home, or, if you would like the information in a different form. To help us respond to your needs, please make any request in writing.

Your right to inspect and copy your health information: You have the right to inspect and / or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to inspect and / or copy your health information to be in writing.

Your right to amend your health information: You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.

Your right to receive an accounting of the disclosures we have made of your records: You have the right to request that we give you an accounting of the disclosures we have made of your health information for the last six years before the date of your request. The accounting will include all disclosures except: those disclosures required for your treatment, to obtain payment for your services, or to run our practice, those disclosures made to you, those disclosures necessary to maintain a directory of the individuals in our facility or to individuals involved with your care, those disclosures for national security or intelligence purposes

those disclosures made to correctional officers or law enforcement officers, those disclosures that were made prior to the effective date of the HIPAA privacy law. We will provide the first accounting within any 12month period without charge. There is a fee for any additional requests during the next 12months. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request.

Your right to obtain a paper copy of this notice: If you have agreed to receive a privacy notice by email, you may request a paper copy at any time.

Our duties: We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your 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 our privacy notices. If we make a change to the terms of our privacy agreement we will notify you in writing when you come in for an adjustment or by mail. If we make a change in our privacy terms the change will apply for all of your health information in our files.

Re-disclosure: Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

Your right to complain: You may complain to us or to the Secretary for Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be addressed to: DHHS, Office of Civil Rights, 200 Independence Ave., SW, Room 509F, HH Building, Washington, DC 20201. To contact us: Vitality Chiro+Energy, 750 Sheridan Lake Rd., Rapid City, SD 57702

This notice is effective as of 2005. This notice will expire seven years after the date upon which the record was created. By signing below, I acknowledge that I have received copy of this notice.

Patient Name Printed	Date
Patient Signature	Authorized Provider Representative
Personal Representative Printed	Personal Representative Signature
Description of personal representative's authority to act for the patient	