ADVANCED CHIROPRACTIC OF DALLAS PLLC

ALI ELAHI, DC
16479 Dallas Parkway, Suite 745, Addison, TX 75001
info@AdvancedChiropracticOfDallas.com

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic or tests on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic, Ali Elahi, now and in the future.

I have had the opportunity to discuss with the doctor of chiropractic and/or with other office clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand the results are not guaranteed.

I understand that the doctor may use his hands or a mechanical instrument upon my body in such a way as to move joints, and that this may cause an audible “pop” or “click” and a sensation of movement.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injury, strokes, dislocations, falls, dizziness, headaches, burns with modalities and sprains. I understand that some patients will feel some stiffness and soreness following the first few days of treatment. I do not expect the doctor to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I also understand the availability of other treatment options like: self-administered over-the-counter analgesics and rest, medical care and prescription drugs such as anti-inflammatory and muscle relaxants and pain-killers, hospitalization, and surgery.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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 Patient Name:_____

Signature:_____

Date: _____

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Official Declaration to All Patients of Advanced Chiropractic of Dallas PLLC

Dr. Ali Elahi does not treat medical conditions like acid reflux, hiatal hernia, GERD, asthma, heart disease, lung disease, gastrointestinal disease, mental disease, hernias, cancer or any medical conditions listed on the ICD 10 codes for medical diseases. Dr. Elahi only diagnoses and treats the vertebral subluxation complex of the spine as well as biomechanics of the rib cage and extremities. By reading and understanding this disclosure, I am acknowledging that I understand that Ali Elahi, DC will only accept me as a patient for vertebral subluxations and/or biomechanical conditions in the chiropractic care of the human body at Advanced Chiropractic of Dallas PLLC.

We look forward to serving your chiropractic needs at Advanced Chiropractic of Dallas.

Sincerely,

Dr. Ali Elahi
Chiropractor

Patient Signature:_____

Date:_____

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HIPPA Privacy Notice

We may use and disclose your PHI (private health information) in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We may also disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute. We may use or disclose your PHI for workers compensation and similar programs. We may use a sign-in sheet at the front desk and we may call you in to see the doctor by name. We may contact you by mail or phone, at your residence, to remind you of appointments or to provide information about treatment alternatives. Unless you instruct us otherwise, we may mail you a postcard reminding you to make an appointment and we may leave a message for you on any answering device or with any person who answers the phone at your residence.
You can make a reasonable request for us to use alternative methods of communicating with you in a confidential manner. These requests must be submitted in writing in a clear and concise fashion. We are not required to agree to your request. However, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when information is necessary to treat you. Rights that you have:
You have the right to request restrictions on some of the uses or disclosures described above. Except as stated, we are not required to agree to such restrictions.
You have the right to inspect and obtain copies of your medical Information. (A fee for the costs of copying, mailing, labor and supplies associated with your request will be charged.)
You have the right to request amendments to your medical information. Such requests must be in writing, and must state the reason for the requested amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights. You have the right to request an accounting of any disclosure we make of your medical information except for disclosures we make to you, to carry out treatment, payment or healthcare operations, as requested by your written authorization, as permitted or required under 45 CFR 164.502, for emergency or notification purposes, for national security or Intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law. You have the right to receive a paper copy of this notice. To obtain a paper copy of this notice, please contact our office manager or the treating doctor. You have the right to file a complaint if you believe your privacy rights have been violated. You may file a complaint with our practice or with the Secretary of the Department of Health and Human Services . All complaints must be submitted in writing and addressed to this office at the above address. You will not be penalized for filing a complaint. This privacy policy is subject to change as circumstances dictate. Any changes will be effective upon the release of a revised privacy policy, which will be made available to patients upon request. Please sign and date below, acknowledging that you have read this policy and that you consent to the terms of our privacy policy as stated in this notice.

Signature:_____ Date:_____

ADVANCED CHIROPRACTIC OF DALLAS PLLC, DR. ALI ELAHI, D.C.
PATIENT QUESTIONNAIRE

PATIENT INFORMATION:

Name_____ Date_____
Address_____ City _____
State_____ Zip_____ Male / Female Birthdate_____
Phone_____ E-mail_____
Emergency Contact Name_____ Phone_____

SYMPTOMS:

Main Complaint_____ How Often_____
When did it start?_____ Getting Better or worse?_____
Rate the Pain (0 is NO pain, 10 is UNBEARABLE pain) 1 2 3 4 5 6 7 8 9 10
What activity bothers it the most?_____
When is it at its best?_____
When is it at its worse?_____
Secondary Complaint_____

HEALTH HISTORY

PLEASE CIRCLE ALL THAT APPLY

AIDS/HIV	Allergy Shots	Anemia	Anorexia	Appendicitis	Arthritis
Asthma	Bleeding	Breast Lump	Bronchitis	Bulimia	Cancer
Cataracts	Chicken Pox	Depression	Diabetes	Emphysema	Epilepsy
Fractures	Glaucoma	Goiter	Gonorrhea	Gout	Heart dx
Hepatitis	Hernia	Herniated disc	Herpes	Kidney dx	Liver dx
Measles	Migraines	Miscarriage	Mono	M.S.	Prostrate
Prosthesis	Implants	Rheumatoid	Stroke	Pneumonia	Implants
Polio	Parkinson's	Thyroid	Tonsillitis	Tumors	Ulcers
Stents	Fibromyalgia	High Cholesterol			

Other_____
Are you Pregnant? Y / N
Have you received chiropractic care before? Y / N
Previous Surgeries and Dates_____
_____
List Medications_____
_____

List Family Illness History_____
_____

PATIENT SINGNATURE_____ DATE _____