

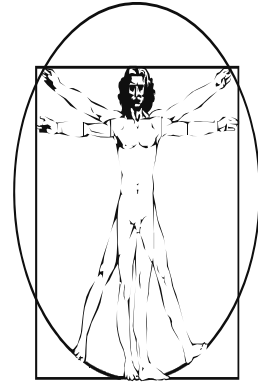
# Lake Tahoe Wellness Center

## Office policy

Thank you for your confidence in seeking modern Chiropractic as a method to restore your health *Naturally*. Shortly, you will be interviewed by the doctor. After reviewing your completed, confidential health questionnaire, should the doctor feel that your condition be best treated by another health practitioner, you will be advised and referred accordingly. However, should your condition fall within the scope of Chiropractic, a thorough consultation will be undertaken to document your case history. A comprehensive Chiropractic examination will then be conducted to determine the cause of your problem(s).

The examination consists of:

- ✓ *Postural analysis*
- ✓ *Physical examination*
- ✓ *Orthopedic and Neurological examination*
- ✓ *Specific Chiropractic examination*
- ✓ *Surface Electromyography and Thermography*
- ✓ *Radiology (if required)*



You will most likely receive an adjustment with this first visit. This will be discussed with you. After this initial session, examination findings will be interpreted. During your second visit, the doctor will explain her findings and will make recommendations as to the Chiropractic Adjustment Program required in your particular case.

Please Note: In order to achieve the maximum benefit from your Chiropractic Adjustments, it is necessary to follow the program outlined by Dr. Lily Kuehne.

### FEE SCHEDULE

<u>Procedure</u>	<u>Fee</u>
<u>Consultation</u>	<u>Complimentary</u>
<u>Examination</u>	<u>\$80.00</u>
<u>X-rays</u>	<u>\$80.00 to \$190.00</u>
<u>Adjustments</u>	<u>\$40.00</u>
<u>Re-examinations</u>	<u>\$20.00</u>
<u>Custom Made Orthotics</u>	<u>\$300.00</u>
<u>Other Supplies</u>	<u>Ask our staff</u>

# Lake Tahoe Wellness Center

## Confidential Introduction For Children to 5yrs.

It is a pleasure to welcome you to our family of happy and healthy chiropractic practice members. Please let us know if there is any way that we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Please circle your preference of phone number we use to contact you.  
Mailing Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Email address: \_\_\_\_\_  
Would you like to receive news regarding our office via email? \_\_\_ Yes \_\_\_ No  
Parents/Guardians: \_\_\_\_\_  
Who can we thank for referring you to our office? \_\_\_\_\_

### What can we help you with?

What is your purpose for contacting us?

\_\_\_\_\_

Any other health problems?

\_\_\_\_\_

Check any of the following conditions your child has suffered from:

<input type="checkbox"/> Ear infections	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Seizures	<input type="checkbox"/> Asthma
<input type="checkbox"/> Allergies	<input type="checkbox"/> Digestive problems	<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Colic
<input type="checkbox"/> Bed wetting	<input type="checkbox"/> Car accident	<input type="checkbox"/> Car accident	<input type="checkbox"/> Chronic colds
<input type="checkbox"/> Recurring fevers	<input type="checkbox"/> Temper tantrums	<input type="checkbox"/> Headaches	<input type="checkbox"/> Growing pains
<input type="checkbox"/> Back pains	<input type="checkbox"/> Neck pains	<input type="checkbox"/> Other: _____	

Relevant family history: \_\_\_\_\_

Previous Chiropractor: \_\_\_\_\_

Date of last visit: \_\_\_/\_\_\_/\_\_\_ Reason: \_\_\_\_\_

Name of Pediatrician: \_\_\_\_\_

Date of last visit: \_\_\_/\_\_\_/\_\_\_ Reason: \_\_\_\_\_

Number of doses of Antibiotics your child has taken:

During the past six months: \_\_\_\_\_, Total during his/her lifetime: \_\_\_\_\_ List: \_\_\_\_\_

Vaccination history: \_\_\_\_\_

Other medications: \_\_\_\_\_

## Prenatal and Birth History

Name of Obstetrician / Midwife: \_\_\_\_\_  
Complications during pregnancy? Y or N Describe: \_\_\_\_\_  
Ultrasounds during pregnancy? Y or N Number: \_\_\_\_\_  
Medications during pregnancy? Y or N Describe: \_\_\_\_\_  
Cigarette/alcohol use during pregnancy? Y or N Amount: \_\_\_\_\_  
Medications during birth? Y or N Describe: \_\_\_\_\_  
Location of birth: \_\_\_ Hospital \_\_\_ Birthing center \_\_\_ Home  
Birth intervention: \_\_\_ Forceps \_\_\_ Vacuum extraction \_\_\_ C-birth  
\_\_\_ Other: describe \_\_\_\_\_  
\_\_\_ Emergency \_\_\_ Planned

## Feeding History

Breast fed: Y or N How long: \_\_\_\_\_ Solids introduced at: \_\_\_\_\_ months  
Formula fed: Y or N How long: \_\_\_\_\_ Cow's milk introduced at: \_\_\_\_\_ months  
Food/Juice allergies or intolerance: Y or N Describe: \_\_\_\_\_

## Developmental History

During the following times your child's spine is the most vulnerable to stress and should routinely be checked by a Doctor of Chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

\_\_\_\_\_ Respond to sound \_\_\_\_\_ Respond to visual stim. \_\_\_\_\_ Hold head up  
\_\_\_\_\_ Sit up \_\_\_\_\_ Cross crawl \_\_\_\_\_ Stand alone \_\_\_\_\_ Walk alone

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs, etc.)

Was this the case for your child? Y or N Describe: \_\_\_\_\_

Is/has your child been involved in any high impact or contact type sports? (i.e. soccer, football, gymnastics, baseball, martial arts, snowboarding, skiing, etc.)

Y or N Describe: \_\_\_\_\_

Has your child been seen in an emergency basis? Y or N Describe: \_\_\_\_\_

Other traumas not described above? Y or N Describe: \_\_\_\_\_

Surgeries? Y or N Describe: \_\_\_\_\_

Any childhood diseases? Y or N Describe: \_\_\_\_\_

We are here to serve you, and encourage you to ask questions.  
Your participation is vital and will help determine your child's results.

### AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize this office and its Doctors to administer care to my child as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Witnessed: \_\_\_\_\_ Date: \_\_\_\_\_

## Dr. Lily M. Kuehne, D.C.

### Terms of Acceptance and Informed Consent

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for us both to be working towards the same objective. We do not offer to diagnose or treat any disease or condition other than vertebral subluxation.

If during the course of the 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 care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

A patient in coming to the Doctor of Chiropractic, requests and consents to the performance of chiropractic adjustments and other chiropractic procedures and analysis, including if necessary, diagnostic x-rays. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor will not give a Chiropractic adjustment or health care, if she/he is aware that such care may be contra-indicated. It is the patient's responsibility to make it known or to learn through health care procedures whatever he/she is suffering from. A Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

**Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine.

**Health:** A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

**Vertebral subluxation:** A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

I \_\_\_\_\_ have read and fully understand the above statements.

(Print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

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(Signature of parent or guardian)

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(Witness to signature)

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(Date)

# Lake Tahoe Wellness Center Notice of Privacy Practices

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

**Summary:**

By law, we are required to provide you with our Notice of Privacy Practices. This Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information.
2. The right to request corrections to your information.
3. The right to request that your information be restricted.
4. The right to request confidential communications.
5. The right to a report of disclosures of your information, and;
6. The right to a paper copy of this Notice.

We want to assure your medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private.

If you have any questions about this Notice, the name and phone number of our contact person is listed on this page.

**Effective Date of this Notice: January 1, 2009**

**Contact Person: *Tiffany***

**Phone Number: *530-546-8201***

### **Acknowledgement of Notice of Privacy Practices**

I hereby acknowledge that I have received a copy of this practice's **NOTICE OF PRIVACY PRACTICES**. I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that this practice will offer me updates to this **NOTICE OF PRIVACY PRACTICES** should it be changed in any way.

\_\_\_\_\_  
Parent/guardian **print name**

\_\_\_\_\_  
Parent/guardian **sign name**

\_\_\_\_\_  
**Date**

( ) Patient refused to sign

( ) Patient was unable to sign because of: \_\_\_\_\_