New Patient | Child

Thank you for choosing Innovative Health & Wellness Group for your family's holistic and integrative healthcare needs! Please have this packet filled out and emailed to frontdesk@evvdc.com **the day before your visit** so the doctor has time to review your health concerns.

When you come in for your appointment, please bring with you:

- A valid driver's license
- A copy of your insurance card

Note: We are collecting your insurance information for laboratory purposes only, so we have your policy on file if your doctor requests laboratory analysis. All other services are cash pay only.

If your child has had laboratory testing performed in the last 3 months, please bring that with you to your appointment, as well as any imaging done in the last calendar year.

If you have any questions, please do not hesitate to our friendly front desk staff for clarification!

PATIENT INFORMATION

Name (first, last) _____ DOB (MM/DD/YEAR) _____

Age _____ Gender _____ Parent/Guardian Name(s) _____

# of Siblings _____ Names and Ages _____

Address _____ City, State _____

Zip Code _____ Cell _____ Email _____

How did you hear about us? _____

Please indicate your preferred method of contact (□ Call □ Text □ Email)

INSURANCE INFORMATION

Policy Holder Name (first, last) and DOB

_____

Policy Holder Relationship to Patient _____ Primary Insurance Company _____

Policy Number _____ Group Number _____

Insurance Address _____

Insurance Phone Number _____ Preferred Pharmacy _____

Preferred Pharmacy Address _____

Preferred Pharmacy Phone Number _____

CANCELLATION AND NO-SHOW POLICIES

At Innovative Health & Wellness Group, we will always strive to deliver the highest standard and efficiency of care. To do this, we need your help! No shows and late cancelations inconvenience the individuals on our waitlist who need access to the services rendered in our office in a timely manner. In an effort to reduce such occurrences, we are implementing the following cancellation and no-show policy that is effective immediately as of May 1, 2020.

PLEASE NOTE: due to COVID-19, we are unable to offer returns or refunds on any supplements, oils, or equipment purchased in our office. All sales are final.

We request you give our office 24-hour notice in the event you need to reschedule your appointment. Our office number is 214-972-0302 and our email is frontdesk2@evvdc.com. If an appointment is canceled within 24-hours of your scheduled appointment, a **$30.00 late fee** will be assessed to you. Our office works diligently to collect finalized labs, evaluating the results, and determining supplement recommendations that are personalized to you and your healthcare needs. Because of this, we require 48-hour notice if you need to reschedule lab work or diagnostic consultations. If 48-hour notice is not given, we will need to collect for the time that went into the preparation for that appointment and a **$50.00 fee** will be assessed to you. If you miss an appointment and do not give 24-hour advance notice, a **$50.00 no-show fee** will be assessed to you.

If you are late for an appointment, please know we will see you as soon as possible but your visit may be shortened in length. Additionally, if you are 10 minutes late to your appointment, a **$30.00 late fee** will be assessed to you. Our office makes reminder calls 24 hours before your scheduled appointment, or through text or email that you indicated preferences for on your intake paperwork. *It is ultimately the patient's responsibility to remember their scheduled appointments.*

This fee will be billed to you directly and is not covered by your insurance. If you don't have a future appointment scheduled, this fee will need to be collected in a timely manner and if not, will be subject to collections. We thank you for your support and understanding on this matter, and look forward to serving your healthcare needs in our office.

_____ _____ Date _____/_____/_____

Signature of Patient Printed name

_____ _____

Signature of Guardian, if patient is a minor or dependent Relationship to patient

HEALTH CONCERNS

Please list, in order of importance, your health concerns for your child:

1. _____ 3. _____

2. _____ 4. _____

Have you seen any other doctors of the above health concern(s)? Y N If so, please describe the treatment given at the other office(s): _____

_____

PERSONAL HEALTH HISTORY

Please indicate if your child has ever in the past (mark with an x) or,

is currently experiencing (circle) the following symptoms.

__Ear Infections __Scoliosis __Seizures

__Chronic Colds
__Asthma
__Recurring Fevers
__Sports Injury
__Temper Tantrums
__Slow Physical Development
__Digestive Problems
__Allergies
__Bed Wetting
__Growing Pains
__Difficulty Sleeping
__Slow Mental Development
__Colic
__ADD/ADHD
__Car Accident
__Other Pain
__Diabetes
__ Other

Vaccination status _____

Adverse vaccine events? Y N Reaction _____

Has your child ever fallen from a high place? His his/her head? Concussion? Y N

Please list any and all traumas or injuries and the year they occurred. _____

_____

Please list hospitalizations, surgeries, major illnesses and/or medical procedures and the year they occurred.

_____

_____

Frequent antibiotic use (e.g. ear infections, sickness, acne)? __Y __ N How many times this year? _____

How long have you been in your current home? _____

Have you noticed any potential risks of mold exposure in your home? (e.g. mold growths, leaky faucets or dishwashers, roof leaks) If so, where? _____

Please list all prescription and over-the-counter medications with dosage that your child is taking and for what symptom. If not currently on medications, please indicate that below by writing "NONE".

1. _____ (Name, dosage) _____ (Symptom)
2. _____ (Name, dosage) _____ (Symptom)
3. _____ (Name, dosage) _____ (Symptom)
6. _____ (Name, dosage) _____ (Symptom)
7. _____ (Name, dosage) _____ (Symptom)
8. _____ (Name, dosage) _____ (Symptom)

4. _____ 9. _____

(Name, dosage) (Symptom) (Name, dosage) (Symptom)

5. _____ 10. _____

(Name, dosage) (Symptom) (Name, dosage) (Symptom)

DIET AND LIFESTYLE

Please describe your child's current diet and any foods you are avoiding and why.

_____

_____

List any real or suspected allergies/sensitivities to drugs, food, or environmental sources.

_____

_____

Does your child do any physical activity? Please describe what type and how often.

_____

PRENATAL AND BIRTH HISTORY

Complications during pregnancy? Y N If yes, then please describe_____

Ultrasounds during pregnancy? Y N If yes, how many and which months_____

Any medications taken before or during delivery_____

Alcohol/Cigarettes/Drugs During Pregnancy? Y N Was your baby full term?_____

Location of Birth (Circle One): Hospital Home Birthing Center How long was the labor?_____

Birthing Interventions (Circle All That Apply): Epidural Forceps Vacuum Extraction VBAC C-Section

If C-Section, was it emergency or planned? _____

Any complications with delivery?_____

Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.

Category I

Feeling that bowels do not empty completely 0 1 2 3
Lower abdominal pain relieved by passing stool or gas 0 1 2 3
Alternating constipation and diarrhea 0 1 2 3
Diarrhea 0 1 2 3
Constipation 0 1 2 3
Hard, dry, or small stool 0 1 2 3
Coated tongue or "fuzzy" debris on tongue 0 1 2 3
Pass large amount of foul-smelling gas 0 1 2 3
More than 3 bowel movements daily 0 1 2 3
Use laxatives frequently 0 1 2 3

Category II

Increasing frequency of food reactions 0 1 2 3
Unpredictable food reactions 0 1 2 3
Aches, pains, and swelling throughout the body 0 1 2 3
Unpredictable abdominal swelling 0 1 2 3
Frequent bloating and distention after eating 0 1 2 3

Category III

Intolerance to smells Intolerance to jewelry 0 1 2 3
Intolerance to shampoo, lotion, detergents, etc 0 1 2 3
Multiple smell and chemical sensitivities 0 1 2 3
Constant skin outbreaks 0 1 2 3

Category IV

Excessive belching, burping, or bloating 0 1 2 3
Gas immediately following a meal 0 1 2 3
Offensive breath 0 1 2 3
Difficult bowel movements 0 1 2 3
Sense of fullness during and after meals 0 1 2 3
Difficulty digesting proteins and meats; undigested food found in stools 0 1 2 3

Category V

Stomach pain, burning, or aching 1-4 hours after eating 0 1 2 3
Use of antacids 0 1 2 3
Feel hungry an hour or two after eating 0 1 2 3
Heartburn when lying down or bending forward 0 1 2 3
Temporary relief by using antacids, food, milk, or carbonated beverages 0 1 2 3
Digestive problems subside with rest and relaxation 0 1 2 3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine 0 1 2 3

Category VI

Difficulty digesting roughage and fiber 0 1 2 3
Indigestion and fullness last 2-4 hours after eating 0 1 2 3
Pain, tenderness, soreness on left side under rib cage 0 1 2 3
Excessive passage of gas 0 1 2 3
Nausea and/or vomiting 0 1 2 3
Stool undigested, foul smelling, mucus like, greasy, or poorly formed 0 1 2 3
Frequent loss of appetite 0 1 2 3

Category VII

Abdominal distention after consumption of fiber, starches, and sugar 0 1 2 3
Abdominal distention after certain probiotic or natural supplements 0 1 2 3

Decreased gastrointestinal motility, constipation 0 1 2 3
Increased gastrointestinal motility, diarrhea 0 1 2 3
Alternating constipation and diarrhea 0 1 2 3
Suspicion of nutritional malabsorption 0 1 2 3
Frequent use of antacid medication 0 1 2 3

Category VIII

Greasy or high-fat foods cause distress 0 1 2 3
Lower bowel gas or bloating several hours after eating 0 1 2 3
Bitter metallic taste in mouth, especially in the morning 0 1 2 3
Burpy, fishy taste after consuming fish oils 0 1 2 3
Unexplained itchy skin 0 1 2 3
Yellowish cast to eyes 0 1 2 3
Stool color alternates from clay colored to brown 0 1 2 3
Reddened skin, especially palms 0 1 2 3
Dry or flaky skin and/or hair 0 1 2 3
History of gallbladder attacks or stones 0 1 2 3
Have you had your gallbladder removed? YES NO

Category IX

Acne and unhealthy skin 0 1 2 3
Excessive hair loss 0 1 2 3
Overall sense of bloating 0 1 2 3
Bodily swelling for no reason 0 1 2 3
Hormone imbalances 0 1 2 3
Weight gain 0 1 2 3
Poor bowel function 0 1 2 3
Excessively foul-smelling sweat 0 1 2 3

Category X

Crave sweets during the day 0 1 2 3
Irritable if meals are missed 0 1 2 3
Depend on coffee to keep going/get started 0 1 2 3
Get light-headed if meals are missed 0 1 2 3
Eating relieves fatigue 0 1 2 3
Feel shaky, jittery, or have tremors 0 1 2 3
Agitated, easily upset, nervous 0 1 2 3
Poor memory, forgetful between meals 0 1 2 3
Blurred vision 0 1 2 3

Category XI

Fatigue after meals 0 1 2 3
Crave sweets during the day 0 1 2 3
Eating sweets does not relieve cravings for sugar 0 1 2 3
Must have sweets after meals 0 1 2 3
Waist girth is equal or larger than hip girth 0 1 2 3
Frequent urination 0 1 2 3
Increased thirst and appetite 0 1 2 3
Difficulty losing weight 0 1 2 3

Category XII
Cannot stay asleep 0 1 2 3
Crave salt 0 1 2 3
Slow starter in the morning 0 1 2 3
Afternoon fatigue 0 1 2 3
Dizziness when standing up quickly 0 1 2 3
Afternoon headaches 0 1 2 3
Headaches with exertion or stress 0 1 2 3
Weak nails 0 1 2 3

Category XIII
Cannot fall asleep 0 1 2 3
Perspire easily 0 1 2 3
Under a high amount of stress 0 1 2 3
Weight gain when under stress 0 1 2 3
Wake up tired even after 6 or more hours of sleep 0 1 2 3
Excessive perspiration or perspiration with little or no activity 0 1 2 3

Category XIV
Edema and swelling in ankles and wrists 0 1 2 3
Muscle cramping 0 1 2 3
Poor muscle endurance 0 1 2 3
Frequent urination 0 1 2 3
Frequent thirst 0 1 2 3
Crave salt 0 1 2 3
Abnormal sweating from minimal activity 0 1 2 3
Alteration in bowel regularity 0 1 2 3
Inability to hold breath for long periods 0 1 2 3
Shallow, rapid breathing 0 1 2 3

Category XV
Tired/sluggish 0 1 2 3
Feel cold—hands, feet, all over 0 1 2 3
Require excessive amounts of sleep to function properly 0 1 2 3
Increase in weight even with low-calorie diet 0 1 2 3
Gain weight easily 0 1 2 3
Difficult, infrequent bowel movements 0 1 2 3
Depression/lack of motivation 0 1 2 3
Morning headaches that wear off through the day 0 1 2 3
Outer third of eyebrow thins 0 1 2 3
Thinning of hair on scalp, face, or genitals, or excessive hair loss 0 1 2 3

Dryness of skin and/or scalp 0 1 2 3
Mental sluggishness 0 1 2 3

Category XVI
Heart palpitations 0 1 2 3
Inward trembling 0 1 2 3
Increased pulse even at rest 0 1 2 3
Nervous and emotional Insomnia 0 1 2 3
Night sweats 0 1 2 3
Difficulty gaining weight 0 1 2 3

Category XVII (Males Only)
Urination difficulty or dribbling 0 1 2 3
Frequent urination 0 1 2 3
Pain inside of legs or heels 0 1 2 3
Feeling of incomplete bowel emptying 0 1 2 3
Leg twitching at night 0 1 2 3

Category XVIII (Males Only)
Decreased libido 0 1 2 3
Decreased number of spontaneous morning erections 0 1 2 3
Decreased fullness of erections 0 1 2 3
Difficulty maintaining morning erections 0 1 2 3
Spells of mental fatigue Inability to concentrate 0 1 2 3
Episodes of depression 0 1 2 3
Muscle soreness 0 1 2 3
Decreased physical stamina 0 1 2 3
Unexplained weight gain 0 1 2 3
Increase in fat distribution around chest and hips 0 1 2 3
Sweating attacks 0 1 2 3
More emotional than in the past 0 1 2 3

Category XIX (Menstruating Females Only)
Perimenopausal 0 1 2 3
Alternating menstrual cycle lengths 0 1 2 3
Extended menstrual cycle (greater than 32 days) 0 1 2 3
Shortened menstrual cycle (less than 24 days) 0 1 2 3
Pain and cramping during periods 0 1 2 3
Scanty blood flow 0 1 2 3
Heavy blood flow 0 1 2 3
Breast pain and swelling during menses 0 1 2 3
Pelvic pain during menses 0 1 2 3
Irritable and depressed during menses 0 1 2 3
Acne 0 1 2 3
Facial hair growth 0 1 2 3
Hair loss/thinning 0 1 2 3

Category XX (Menopausal Females Only)

How many years have you been menopausal? _____ Years
Since menopause, do you ever have uterine bleeding? YES NO

Hot flashes	0	1	2	3	*Depression*	0	1	2	3
Mental fogginess	0	1	2	3	*Painful intercourse*	0	1	2	3
Disinterest in sex	0	1	2	3	*Shrinking breasts*	0	1	2	3
Mood swings	0	1	2	3	*Facial hair growth*	0	1	2	3
					Acne	0	1	2	3
					Increased vaginal pain, dryness, or itching	0	1	2	3

CLINICAL CARE RELEASE

_____ has been accepted as a patient to be seen at Innovative Health and Wellness Group.

The patient and/or his/her guardian(s), or legally responsible person(s) desire to be examined by the licensed practitioners and the clinical staff. You the patient, upon signature, give permission/consent to any clinically appropriate examination and therapeutic procedures, as determined by the clinical staff and consented to.

The patient and/or his/her guardian(s), or legally responsible person(s) acknowledge and agree that providers of many disciplines may be in attendance or participate in this clinical evaluation and care process. These individuals will potentially observe all examination and treatment procedures.

Clinical staff: (Please take the time to understand the staff, their roles, and feel free to ask about scope of practice with each one). We have a multi-disciplinary staff to accommodate you.

Dr. Carey Carda, MD

- Medical Doctor
- Clinical Director

Dr. Erin Van Veldhuizen, MSN, FNP-C, DC, DACNB, DCBCN, DCN, CCCN, CCTT

- Family Nurse Practitioner- Certified (Delegation with Elizabeth Seymour, MD)
- Chiropractor
- Diplomat, American Chiropractic Neurology Board
- Diplomat, Chiropractic Board of Clinical Nutrition
- Diplomat, Clinical Nutrition from American Association of Integrative Medicine
- Nutritional Therapy
- Certified Camera Thermographer, International Association of Camera Thermographers

Dr. Paige Phelan, DC

- Chiropractor
- Certified Basic Functional Taping

Dr. Skylar Camacho, DC

- Chiropractor

The patient and/or his/her guardian(s), or legally responsible person(s) acknowledge and agree that there are risks associated with all diagnostic and therapeutic procedures, including those used at Innovative Health and Wellness Group. The procedures ordered by the staff clinicians are recommended because the potential benefits are greater than the potential risks.
The patient and/or his/her guardian(s), or legally responsible person(s) acknowledge and agree that NO promise or guarantee of a cure or outcome has been given. While the Innovative Health and Wellness Group staff will attempt to work with any patient we feel we can assist in recovery or improvement, we also reserve the right to deny or suspend care should the patient's condition warrant it.

The patient and/or his/her guardian(s), or legally responsible person(s) acknowledge and agree that neither the patient or any assigns will hold Innovative Health and Wellness Group, its staff, or its volunteers liable for any actions, non-actions, or outcomes associated with the diagnosis, treatment, and recommendations of the staff.

_____ _____ Date _____/_____/_____

Signature of Patient Printed name

_____ _____

Signature of Guardian, if patient is a minor or dependent Relationship to patient

STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

Innovative Health and Wellness Group appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies complete financial responsibility on your part.

The financial responsibility obligates you to ensure payment in full of our fees and the costs of all testing, including laboratory and other outside tests. We expect these payments at time of service.

The patient and/or his/her guardian(s), or legally responsible person(s) acknowledge and agree that at no time will IHWG be obligated to communicate or bill any insurance company. We will provide you with a detailed statement of services provided should you wish to seek reimbursement independently.

While your specific treatment plan is determined by the clinical staff. The patient and/or his/her guardian(s), or legally responsible person(s) acknowledge and agree that all costs specific to

transportation, lodging, and travel expenses are to be borne by the patient and/or his/her guardian(s), or legally responsible person(s).

I have read the above policy regarding my financial responsibility to Innovative Health and Wellness Group, for providing services to myself or the above-named patient. I certify the information is, to the best of my knowledge, true and accurate. Payment in full and the entire amount of bill incurred by me or the above-named patient is due prior to service rendered.

_____ _____ Date _____/_____/_____

Signature of Patient Printed name

_____ _____

Signature of Guardian, if patient is a minor or dependent Relationship to patient

AUTHORIZATION TO RELEASE INFORMATION

I authorize Innovative Health and Wellness Group to release to appropriate agencies or persons, any information acquired in the course of my or the above-named patient's examination and treatment. This information may be stored and transmitted electronically using appropriate safeguards and/or data encryption.

For more information, please see the HIPAA authorization form and privacy notice, or feel free to ask a member of staff should you need clarification.

_____ _____ Date _____/_____/_____

Signature of Patient Printed name

_____ _____

Signature of Guardian, if patient is a minor or dependent Relationship to patient

EXPERIMENTAL THERAPY STATEMENT

Some of the devices and therapies used at Innovative Health and Wellness Group are proprietary and/or are in the process of gaining regulatory approval. While they are thought by our clinical staff and medical advisory board to have a positive effect, no claim is made that any of the devices listed below diagnose or treat any condition unless specifically evaluated and approved by the Food and Drug Administration for that usage.

- Compounded infusion formulas for the treatment of specific conditions.

- Various compounded medications and nutritional and dietary and supplemental usage combined with conventional medical care.

Additionally, the nutraceuticals and supplements offered may contain elements that have not been assessed by the Food and Drug Administration. While none of these, in the opinion of the clinical staff, pose an unbalanced risk or are inherently unsafe, we as healthcare providers feel you should be made aware that they may not have been proven effective in treating your specific condition.

I have read and acknowledged the above statement.

_____ _____ Date _____/_____/_____

Signature of Patient Printed name

_____ _____

Signature of Guardian, if patient is a minor or dependent Relationship to patient

HIPAA AUTHORIZATION FORM

I authorize Innovative Health and Wellness Group to access, use or disclose my protected health information in the manner described below.

1) IHWG may request and be provided with a copy of prior health records, including protected health information from your current or previous healthcare provider(s).
2) IHWG may communicate with your current or previous healthcare provider(s) in reference to your diagnosis, treatment and care.
3) IHWG staff may communicate internally regarding your case.
4) You have the right to authorize or disallow communication with outside non-clinical personnel (such as a family member) regarding your diagnosis, treatment or care of IWHG.

The following information may be disclosed to, from, or between outside medical personnel and IHWG as it is relevant to your care:

*Medical Records *All treatment records

*Records regarding communicable diseases *Chiropractic records

*Alcohol/Drug abuse treatment records *Any other information relating to my condition

*Mental Health records

All past, present and future periods of healthcare information may be shared for the period of this authorization.

The purpose of the use or disclosure of this information is to facilitate effective and accurate diagnosis and treatment at IHWG, and to comply with state and federal laws.

This authorization is valid beginning on _____/_____/_____ (today's date) and expires one year after the end of your care received at or from IHWG, including any follow-up care and consultations.

I acknowledge that the information used or disclosed under this authorization may be subject to re-disclosure by the person or facility receiving it and would then no longer be protected by federal privacy regulations.

I have the right to refuse to sign this authorization form; however, if I refuse to sign, the staff of IHWG may refuse service if they are unable to gain access to previous medical records. If signed, I have the right to revoke this authorization, in writing, at any time. I acknowledge that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. Please see the HIPAA privacy notice for a more detailed outline of our privacy policy.

In the event I cannot be reached, IHWG may use the following methods to communicate important health information:

___ e-mail provide the email address: _____

___ voicemail (please be aware that voicemails may not be secure): (_____)_____-_____

___ standard mail at the following address: _____

Name of any person(s) allowed to communicate with IHWG and relation to patient:

_____

_____ _____ Date _____/_____/_____

Signature of Patient Printed name

_____ _____

Signature of Guardian, if patient is a minor or dependent Relationship to patient

CHIROPRACTIC TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept a patient for such care, it is essential for both to be working for the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

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

***Health**: The 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 vertebrae 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.*

We do not offer the diagnosis or treatment of any disease. We only offer to diagnose either vertebral subluxation complex and/or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination we encounter unusual findings which are outside the scope of practice for a Doctor of Chiropractic, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatments prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is the specific

adjustment to correct vertebral subluxation. However, we may use other procedures to help your body hold those adjustments.

I, _____ have read and fully understand the above statements.

(Print name)

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

_____ Date _____/_____/_____

Signature of Patient

_____ _____

Signature of Guardian, if patient is a minor or dependent Relationship to patient

DISCLOSURE(S) AND INFORMED CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended medical, chiropractic or diagnostic procedure or drug therapy to be used, so that you may make the informed decision whether or not to undergo the procedure or after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, but recommended to you by us, as your providers.

Details of the diagnostic tests that we run at Innovative Health and Wellness Group are contained in the list at the end of this Disclosure and Informed Consent.

I understand that medical, chiropractic or diagnostic tests or procedure(s) may be necessary or advisable and I voluntarily consent and authorize such tests or procedure(s) as deemed necessary or advisable upon examination. The list of tests and procedure(s) to be performed, and their risk, benefits, is included below, and I have been informed of the risks/hazards of such test or procedure(s).

Just as there may be risks and hazards in continuing my present condition, with or without treatment or procedure(s), there are also risks and hazards related to the performance of medical, chiropractic, or diagnostic procedure(s) planned for me. I realize that common to medical, chiropractic and/or diagnostic procedure(s), is the potential for infection, allergic reaction(s) and, in very rare cases, even death due to severe systemic reaction.

While some of the devices and therapies used at Innovative Health and Wellness Group are thought by our clinical staff to have a positive effect on your condition, no claim is made that any of the devices listed below diagnose or treat any condition unless specifically evaluated and approved by the Food and Drug Administration for that usage.

RISKS ASSOCIATED WITH DIAGNOSTIC AND THERAPEUTIC MODALITIES

As with any healthcare procedure, there are certain complications that may arise during diagnostic procedure(s) and therapeutic intervention(s). The following procedure(s) and intervention(s) may or may not be used in your specific case. The complications are outlined below and include but are not limited to:

RPSS
Risks include pain, skin irritation, muscle spasms or minor electrical burn at the end point of contact

Gaze Stability
Risks for gaze stability exercises include temporary discomfort in the neck, changes to vision, dizziness, nausea, light-headedness, fatigue and headaches

Vibracussor, balance testing, NSI and other Neuromuscular Re-Education
Risks include local soreness, increase in symptoms, fatigue, headache, light-headedness and dizziness; rarely therapy may result in loss of balance with subsequent fall with injury.

OVARD:
Benefits: The patented Off Vertical Axis Rotational Device (OVARD) provides neurological rehabilitation to patients whose lives have been affected by concussions, physiological and neurological disorders, and other conditions that may benefit from brain-based therapy. It targets the vestibular system, which affects balance, spatial orientation and movement. This rotation stimulates the vestibular system to encourage neural activity in parts of the brain that have been affected by illness or injury.
Risks: Include temporary light-headedness, dizziness, nausea, anxiety, headache and malaise. Risks that are uncommonly encountered include fainting, changes to blood pressure and heart rate and death.

Chiropractic Manipulation and Manual Myofascial Therapy:
Reactions that are most commonly reported are local soreness/discomfort and bruising, headaches, fatigue, radiating discomfort, dizziness. The vast majority of the aforementioned conditions will be resolved within 48 hours. Rare side effects include: fracture or joint injuries, isolated cases with underlying physical defect, deformities or pathologists, muscle and ligament sprain, disc herniations, cauda equina syndrome, compromise of vertebrobasilar artery (i.e stroke).

Cold Laser Therapy:
Benefits: Cold Laser Therapy is a pure form of light energy of a specific color and wavelength that does not increase thermal temperature of what it is contacting. The laser light interacts with tissue causing the occurrence of certain photochemical reactions and stimulating the neural biological process. It is a non-invasive procedure, meaning that it does not require a surgical incision. This means that there is no prolonged recovery time. Laser therapy also does not involve taking any medications, and many patients prefer to avoid taking medications.
Risks: Patients do not typically get full relief or resolution from their pain symptoms after the first treatment. It takes a series of days after treatments, but for most patients this sensation is short term, lasting for a couple of days.

Blood Draw:
The risks of taking blood include discomfort, local bruising, redness and swelling of the vein and the rare risks of fainting and infection.

IV Therapy:
The risks of taking blood and/or IV therapy include discomfort, local bruising, redness and swelling of the vein and the rare risks of fainting and infection. Severe reactions include allergic reaction, anaphylaxis, infection, cardiac arrest and death.

The patient and/or his/her guardian(s), or legally responsible person(s) acknowledge and agree that there are risks associated with all diagnostic and therapeutic procedures, including those used at Innovative Health and Wellness Group. The procedures order the staff clinicians are recommended because the potential benefits are greater than the potential risks.

The patient and/or his/her guardian(s), or legally responsible person(s) acknowledge and agree that NO promise or guarantee of a cure or outcome has been given. While the Innovative Health and Wellness Group staff will attempt to work with any patient, we feel we can assist in the recovery or improvement, we also reserve the right to deny or suspend care should the patient's condition warrant it.

I have been given the opportunity to discuss with my medical provider, and to ask questions about my condition and treatment, risks of non-treatment and the medical, chiropractic or diagnostic procedure(s) to be used to treat my condition, and the risks and hazards of such treatment and procedure(s), and I believe that I have sufficient information to give this informed consent. I acknowledge that this DISCLOSURE AND INFORMED CONSENT have been fully explained to me, that I have read it or have had it read to me and that I understand its contents.

The patient and or his/her guardian(s), or legally responsible person(s) desire to be examined by Innovative Health and Wellness Group staff. They give permission/consent to any clinically appropriate examination and therapeutic procedures as determined by the clinical staff.

_____ _____ Date _____/_____/_____

Signature of Patient Printed name

_____ _____

Signature of Guardian, if patient is a minor or dependent Relationship to patient