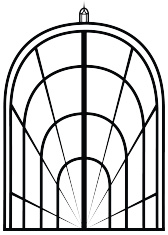

ARCADE
CHIROPRACTIC

Dr. Andy Ingram
401 Euclid Ave. STE 140
Cleveland, OH 44114
(216) 522-0300
www.arcadechiro.com

NAET NEW PATIENT INFORMATION

Patient Name_____ Date_____

Address_____

City_____State_____ Zip_____

Birthdate_____ Age_____ Sex F_____ M_____

Email _____

Phone Number_____

Emergency Contact

Emergency Contact's Name_____

Relationship to Patient_____

Phone Number_____

Emergency Contact's Name_____

Relationship to Patient_____

Phone Number_____

Whom may we thank for referring you?_____

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Health History

List all of the previous treatments that you have received for this condition and the name(s) of previous doctors:

Medications	Supplements	Known Allergies

Reason for visit: _____

When did your symptoms first appear:_____

Is your condition getting better or worse: Better Worse

How often do you have symptoms: _____

Rate the severity of your symptoms on a scale of 1 (lowest) to 10 (highest): _____

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NAET TREATMENT CONSENT

I, _____, certify that Dr. Andy Ingram does not claim to cure any illness or disease with NAET (Nambudripad's Allergy Elimination Techniques).

I understand that NAET is not a medical diagnostic procedure and therefore does not diagnose a disease. Rather, NAET gives the practitioner an indication as to the substance(s) to which a patient may have sensitivity. NAET uses various, standard medically proven diagnostic measures and modalities (allopathic, chiropractic, kinesiological, and acupuncture) to diagnose the patient's condition. The premise behind NAET is to desensitize a patient to a substance(s) using allopathic, chiropractic, acupuncture/acupressure, nutritional, and kinesiological principles so that the patient may not experience hypersensitive symptoms when they have future contact with them.

I understand that I (or my dependent) am to continue all medications and other treatment modalities as they have been prescribed unless otherwise directed by the doctor who prescribed them. During the next 25 hours or after if I (or my dependent) have a life-threatening reaction from the allergen I (or my dependent) was treated or from some other sources, I need to seek immediate emergency help from a physician qualified in emergency treatments, by calling 911 or attending an emergency room at the local hospital. If I (or my dependent) am suffering from a severe allergic reaction to substances, I should consult an appropriate physician and take appropriate medication (such as medication to prevent itching, tissue swelling, fever, cough, pains, infections, mental irritability, violent behaviors, etc.) to keep me (or my dependent's) symptoms under control while I (or my dependent) am treating with NAET treatments. This way essential NAET treatments can be completed without interruption and once I (or my dependent) complete the essential NAET treatments for my (or my dependents) condition, I (or my dependent) may not need to continue pharmaceutical drugs indefinitely.

I understand that for 25 hours after the treatment, I (or my dependent) am to avoid eating, touching, breathing, and coming within 5 feet or more (as instructed by my practitioner) of the substance(s) that I (or my dependent) have received treatment for. If I (or my dependent) come in contact with the substance(s) for which I (or my dependent) am being treated, I realize that the treatment may not work, and I (or my dependent) may have a sensitivity reaction.

I understand that I (or my dependent) must return after the 25 hour avoidance period, preferably within 24 hours but at least within 7 days, to see if I (or my dependent) have cleared for the substance(s). I fully understand that I (or my dependent) may still experience a reaction to the substance(s) of unknown severity if I (or my dependent) come in contact with them if I (or my dependent) did not clear them completely. If I (or my dependent) did not clear them completely, I (or my dependent) may require repeating the procedure (meaning more office visits at my cost) until I (or my dependent) clear them satisfactorily.

I give permission to the clinic to use my (or my dependent's) case study in educating other similar patients or accumulating data for research purposes without disclosing my real name or address. I give permission to take photographs of my (or my dependent's) affected body part(s) (e.g. in the case of a skin condition, etc.) to use in research or patient education purposes without disclosing my real name or address.

I have read, or have had read to me, the above statements and have had the opportunity to ask questions about its content, and by signing below I agree to the term and procedures.

Signature:_____

Printed Name: _____

Dependent's name if a minor:_____

Date: _____

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NAET TREATMENT INSURANCE NOTICE

I understand that NAET treatment is not a procedure covered by medical insurance.

I understand that I am financially responsible for all charges due at the time of service.

Signature:_____

Printed Name: _____

Dependent's name if a minor:_____

Date: _____

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HIPAA RELEASE

AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

As required by the Health Insurance Portability and Accountability Act of 1996 and required by April 14, 2003, Arcade Chiropractic may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the use of and/or disclosure of protected health information described below.

I hereby consent to this practice to use and disclose my protected health information for the purpose of treatment, payment, and operations of my healthcare and this practice. This consent includes contact of and discussion with other healthcare professionals for my care and treatment.

I hereby authorize the use and/or disclosure(s) of the following protected health information that pertains to me: my medical records and diagnoses, including but not limited to all lab/x-ray reports, progress reports, and other information.

I understand that I have the right to:

- Refuse to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether I sign this authorization or not.
- To inspect and obtain a copy of any protected health information disclosed relating to this authorization.
- Receive a signed copy of this authorization.

Signature:_____

Printed Name: _____

Relationship if not patient:_____

Date: _____

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CONSENT TO TREATMENT OF A MINOR

I hereby request and authorize Dr. Andy Ingram to perform diagnostic tests and render chiropractic adjustments, NAET treatments, and/or other treatment to my child _____.

This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above.

IF APPLICABLE: Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Signature:_____

Printed Name: _____

Relationship to Patient:_____

Date: _____