Bender Chiropractic Health and Vitality Center
NEW PATIENT INFORMATION FORM

Please print clearly:

Name _____ Date _____

Address _____ Apt.# _____

City _____ State _____ ZIP _____

Shipping Address _____

_____

Home Phone (____) ____-_____ Cell Phone (____) ____-_____

e-mail address: _____

REFERRED BY: _____

Occupation _____ Employer _____

Date of Birth _____ Age ____ Sex: M/F Height _____ Weight _____

Overall health (circle one): Excellent / Good / Fair / Poor / Other: _____

Chief complaint (reason you are here): (use separate sheet if more room needed)

_____

Previous treatments for this complaint _____

_____

Other complaints or problems: (use separate sheet if needed) _____

_____

Current medications/drugs being taken: (use separate sheet if needed) _____

_____

Are you currently under the care of a physician or other health care professionals?
(If yes, please give name and date of last visit):

_____

Nutritional supplements you are taking: _____

Do you smoke, drink coffee or alcohol? (if yes indicate how much)

Cigarettes _____ Coffee _____ Alcohol _____

BENDER
CHIROPRACTIC
HEALTH & VITALITY CENTER
INTEGRATING NUTRITION & CHIROPRACTIC CARE
HOLISTIC WELLNESS

Name:

What are your chief concerns?

What are the roadblocks that are holding you back from achieving your goals?

What are your goals?

Signature: *Date:*

Informed Consent for BrainTap Sessions

Introduction
At Bender Chiropractic Health & Vitality Center, we offer BrainTap sessions designed to help you achieve mental clarity, relaxation, and improved neurological functioning through a combination of guided visualization, binaural beats, and other relaxation techniques.

Procedure Description
BrainTap is a high-tech relaxation session that uses a headset to deliver gentle light pulses that travel through the retina and ear meridians. The sessions are combined with meditative audio to encourage mental and emotional stress relief, brainwave entrainment, and relaxation. Each session lasts approximately 15-30 minutes, depending on the selected program.

Potential Benefits
The benefits of BrainTap sessions may include:

- Reduced stress and anxiety
- Enhanced sleep quality
- Improved cognitive function and focus
- Increased energy levels
- Greater emotional stability

Potential Risks
The risks associated with BrainTap sessions are minimal but may include discomfort from the headset, light sensitivity for those prone to migraines, and transient disorientation immediately after the session.

Voluntary Participation
Your participation in BrainTap sessions is entirely voluntary, and you are free to discontinue at any time.

Confidentiality
All information disclosed within sessions and the written records pertaining to those sessions are confidential and will not be shared without your written consent, except where the disclosure is required by law.

Acknowledgment and Consent
By signing this form, I acknowledge that I have read and understood the information provided about BrainTap sessions. I have had the opportunity to ask questions, and any questions I have asked have been answered to my satisfaction. I consent to participate in BrainTap sessions under the terms described herein.

Patient Name: _____
Signature: _____
Date: _____

Witness Name: _____
Witness Signature: _____
Date: _____

Bender Chiropractic Health & Vitality Center

New Patient Cancellation Policy

Welcome to Bender Chiropractic Health & Vitality Center! We look forward to serving you on your healthcare journey!

We are reserving about an hour for you to meet with your doctor and our clinical assistant, so short-notice cancellations create a large gap in our schedule where we could be helping other patients.

Because of that, we ask for at least a 24-hour notice if you need to cancel orreschedule your appointment. You can call anytime, just be sure to leave avoicemail with a detailed message if you are calling after hours.

Ifwe don’t receive a 24-hour notice, a $25 cancellation fee will be charged toyour credit card on file.

Thank you!

_____ _____

Signature Date

Section 8: Notice of Privacy Practices Acknowledgement
Initial Uses Authorization Form
Bender Chiropractic Health and Vitality Center

Effective: 4-15-2003

By signing this form, you acknowledge that you were presented with a copy of the Notice of Privacy Practices of Bender Chiropractic Health and Vitality Center. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. The most current Notice of Privacy Practices will be placed on display in the office at all times. You may obtain additional copies of our most current notice by requesting it from our privacy official, Dr. William L. Bender

Bender Chiropractic Health and Vitality Center also uses protected health information for the following reasons: (you may opt out of this authorization). Marketing; internal referral board, testimonials, pictures on bulletin board, or information unrelated to healthcare and other marketing materials. _____ (please initial to give us authorization)

If you have any questions regarding this notice or our health information privacy policies, please contact:
Dr. William L. Bender

You can reach the Privacy Official at: Bender Chiropractic Health and Vitality Center, 33580 Harper Avenue, Clinton Township, MI, 1-586-738-6833
Hours Available: A message may be left for our privacy official any time the clinic is open and your call will be returned within 7 business days.

Your Email address: _____(you may receive PHI through email)

Print Patient Name: _____

Signature Patient/Personal Representative: _____

Relationship of Personal Representative: _____

Date of Signature: _____

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Staff complete only if NO signature is obtained, If it is not possible to obtain the patient s acknowledgment, describe the good faith efforts made to obtain the individual s acknowledgement, and the reasons why the acknowledgement was not obtained.

Patient refused to sign this acknowledgement even though the patient was asked to do so and the patient was given the Notice of Privacy Practices
Other:

_____

Staff Signature: _____date: _____