Health from Within
Chiropractic · Nutrition

Dr. Debra Schroeder, D.C.
www.chiropracticnutritiondublin.com

Patient Nutrition Intake Form

Name_____ DOB ____/____/____ SS#_____

Address _____ City _____ State _____

Zip Code _____ Email _____

Telephone: Home (____) _____ Work (____)_____ Cell (____)_____

Place of Employment_____Occupation_____

Married____ Single____ Divorced____ Widow(er)____ # of children_____

In case of emergency, who should we contact?

Name_____ Phone_____ Relationship_____

Nutritional Informed Consent

According to the Federal Food, Drug and Cosmetic Act, as amended., Section 201 (g) (1) The term "Drug" is defined as: "Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment, or Prevention of disease."

A vitamin, mineral, trace element, amino acid, herb or a homeopathic remedy is not a drug. Although a vitamin, mineral, trace element, amino acid, herb, or homeopathic remedy may have an effect on any disease process or symptom, this does not mean that it can be misrepresented or classified as a drug.

At no time will there be any implied and or stated indication for any patient to cease care under the direction of another physician nor indication for any patient to cease medication as prescribed by his or her physician.

Dr. Debra Schroeder is not nor claims to be a Dietician, Herbalist, Homeopathic physician, Naturopath, or Medical Doctor. She does not treat nor claims to treat infectious disease. Dr. Schroeder advises specific supplementation and diet alterations to support the body as a whole. Any suggested nutritional or dietary advice is not intended as a primary treatment or therapy for any disease or particular symptom.

Nutritional counseling, vitamin recommendations, and nutritional advice is provided solely to upgrade the quality of foods in the patients' diet in order to supply sound nutrition supporting the chiropractic adjustment, physiology, and biomechanical processes to the human body.

I have read and understand the above:

Patient Signature:_____ Date_____

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Nutrition/Holistic Care Explanation of Procedures

Testing Modalities: A symptom survey, muscle testing, blood and urine analysis, and/or saliva testing are used to gather information on your health status. After carefully assessing the information, Dr. Schroeder determines if your body is responding correctly to its environment. Steps are then taken to create a positive change in your physiology to correct the atypical response, creating balance within.

If further testing is needed from outside sources, Dr. Schroeder will explain the importance and direct you to those sources.

Our goal is to create balance within the body to allow for optimum health

First Visit: The focus of the first visit is to create an optimal environment within your body for your Immune and Endocrine System to correct its deficiencies. During your visit, Dr. Schroeder will use a symptom survey and Kinesiological testing to determine your body's weakness and suggest proper dietary means to support your body functions. A brief nutritional analysis will provide Dr. Schroeder with supplementation to provide your natural defenses an optimal healing environment. The number of supplements suggested is determined by your state of health; the average number of supplements recommended during an initial visit is four.

Second Visit: During the second visit, Dr. Schroeder will assess your progression in creating an optimal environment for health. If your body has responded well to your new environment, more stressors will be tested to determine if your body holds more sensitivity. These new found sensitivities will be addressed in the same manner as in visit one. Food, chemical and hormonal sensitivities are usually addressed in visit two and three.

Subsequent Visits: Prior found sensitivities will be monitored along with addressing new sensitivities. The number of visits is determined by your state of health and your health goals. ***Remember, we are working with natural products that do not overpower your own body's healing potential, but rather enhances its natural ability to heal itself.***

Supplements: Supplements prescribed can be purchased in our office for your convenience. We ask that you call with your reorder at least two weeks in advance to allow adequate shipping time from the manufacturer. This will insure no interruption in your supplement and health regimen.

ALL SUPPLEMENT SALES ARE FINAL, NO REFUNDS OR RETURNS

Dr. Schroeder is not a Dietician, Homeopathic physician or Medical Doctor. She does not treat infectious, contagious, or venereal diseases, perform surgery or acupuncture, or prescribe or administer drugs for treatment. Dr. Schroeder performs Clinical Nutrition under her Chiropractic Doctorate license.

I have read and understand the above and agree to abide by these terms listed above

_____ _____
Signature Date

_____ _____
Staff Financial Consultant Date

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Patient Acknowledgement & Consent Form

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Health From Within or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.
- You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

As our patient, we want you to know that we respect the privacy of your personal records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When appropriate, we provide the minimum necessary information to only those we feel are in need of your health care information. This includes information about treatment, payment, and/or health care operations in order to provide health care that is in your best interest.

By my signature below I give my permission to use and disclose my health information.

_____ _____

Patient or Legally Authorized Individual Signature — Date

_____ _____

Print Patient's Full Name

_____ _____

Witness Signature — Date

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Online Consent

Health From Within understands the need to reserve environmental resources. For this reason, we have decided to send statements electronically instead of utilizing many paper products, printer ink, environmental cost of deliver etc., thus decreasing our carbon footprint.
To start receiving your statements electronically, please read and sign the below consent form. We also require a secure e-mail that you check regularly. Please do not use a work e-mail address for these transactions. Employers may monitor these addresses thus having access to your personal information. For your discretion, no diagnosis will be given on these statements.

Consent to Receive Online Statements

I understand the risks of electronically transmitting personal information, including but not limited to: employers and online services having the right to inspect e-mail transmitted through their systems, e-mails not being secure and therefore breached by a third party, etc. Health From Within cannot guarantee, but will use reasonable means to maintain security and confidentiality of e-mail information sent and received. **No diagnosis or other information excluding services and charges will be provided on electronic statements. If you wish to know your diagnosis, please contact Health From Within.**
I understand I will receive electronic statements until I have provided written notice to Health From Within*, signed and dated, to cease the transmission of online statements and to receive hard copy statements.*

Please check **yes or no** if you would like to receive the following electronically:
I consent to receive **office information via e-mail** concerning changes in office hours and vacation days, upcoming events and specials, changes in regulations/fees, appointment reminders etc.

YES ☐ NO ☐

I consent to receive my **billing statement electronically** which I may pay by credit card, check or cash by either phone, mail or in person

YES ☐ NO ☐

I consent and request to receive **appointment reminders** from the following: (no additional charge)

TEXT ☐ E-MAIL ☐ BOTH ☐ NEITHER ☐

I consent to give Dr. Schroeder permission to take **pictures of my posture**- strictly for the purpose of tracking my progress**.** *These pictures will not be on display for ANYONE to see but you and the doctor*

YES ☐ NO ☐

Please print clearly

Patient Name (Please list all family members consent applies to): _____
Parent/Guardian Name (if under 18 years):_____
Phone Number (if you wish to receive texts)_____
Secure E-mail Address:_____
Mailing Address: _____City:_____State:_____Zip Code:_____
Signature:_____ Date:_____

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TIME OF SERVICE

Cancellation Policy: *If you have an appointment that you are unable to keep, we require a **24 hour notice*** so the time may be used to treat another patient. If you fail to show up without cancelling 24 hours prior to your appointed time, you will be charged the following:

Nutrition…….. ½ the scheduled fee ($30 for Nutritional Exam)

Chiropractic…….. $20 fee

Please initial to confirm you have read and understand the above information _____

Time of Service Fees:

Chiropractic Fees

SI belt/Posture Pump/Pillow……..…..$52.00/$150.00-210.00/$50.00
Spinal Manipulation……..$45.00
Extended Examination……..$55.00
X-Ray (per area)……$45.00
Brief Exam……..…….$25.00
Therapy*……..$5-25.00
TOS Adjustment Package (10 visits)……..$405.00
(Therapy will be an additional charge per visit)
Child Wellness Adjustment)……..$25.00
(<10yrs old same appointment time as TOS parent)
** Approximately $2.00 per minute of manual therepy/massage.

Nutrition Fees

Extended Nutritional Exam(>30min).... ..$85.00
Nutritional Exam(@30min)…..$65.00
Specialized Nutritional (@15min)……..$35.00
Quick Check Nutrition* (<10 minutes)....$15.00
Body Composition Test/HSR..……..…$10.00
Supplementation cost depends on product
Blood Read…..……$10.00
*Questions/Testing outside of Nutritional Consult

****All supplement and DME sales are final** **Supplements & DME are nonrefundable**

Consent to Receive Online Information

I understand that by giving my email and Cell Phone number, Health from Within has the ability to send me office updates along with patient information that Dr. Schroeder may find useful for my plan of care. I have provided my email and cell phone to receive these documents.

Secure Email:_____ Secure Cell Phone #:_____

☐ Please check here if you do not wish to receive mobile or email updates from Health From Within

I have read and understand the above financial policy and agree to abide by the terms listed above.

_____ _____
Signature *Date*

_____ _____
Staff Financial Consult *Date*

We are glad you have chosen us for your healthcare needs and look forward to serving you.
Dr. Debra Schroeder and Staff at Health From Within

7243 Sawmill Rd Ste 106 Dublin, OH 43016 (614)-761-3979 Fax (614)682-6181