Sharon A. Vallone DC, FICCP
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469 Buckland Road, South Windsor CT
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drfaraneh
chiropractic physician
469 Buckland Road, South Windsor CT
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Welcome!

Thank you for inviting us to participate in your healthcare. We hope that this relationship will be helpful as you journey towards improved health.

Cost of visits are based on services provided:

New Patient/Initial Consultation	$180
15 Minutes Adjustment, Soft Tissue or Craniosacral Therapy (CST)	$55
30 minutes Adjustment, Soft Tissue, CST &/or Kinesiotaping	$75
New Problem/Reevaluation & Treatment	$100
Tongue Tie Initial Evaluation	$180
Post-Revision Follow Up (exam & minimal treatment)	$55
Post-Revision Follow Up (exam and extensive treatment)	$75
Extensive Phone, Text or Email Consultation	$100/hr
Additional Reports	$50
Pharmacy or other product	Variable
Co-consult w/ Dr. Meila Gruber or Invited Guest	$75-$100
Additional Services	Practitioner's discretion

We have chosen not to participate in any insurance plans. Payment in cash or check is appreciated at the time of service. Upon request, we are able to provide invoices and reports for flex spending reimbursement. Please make checks payable to the individual you scheduled with (Sharon A. Vallone DC, or Dr. Faraneh). Please speak with us about any financial concerns as soon as they arise.

To schedule an appointment, please call 860.432.9923

PATIENT INFORMATION **DATE OF INTAKE**_____

Name: _____ Birthday (M/D/Y): _____ Age: _____ Gender:____

Address:_____
(Street) (City) (Postal Code)
Home #: _____Cell #: _____ Email:_____

Partnership/Marital status: _____# of Children: _____ Occupation: _____

Emergency Contact_____
(Name) (Relationship) (Number)
How would you like to be addressed by our staff?_____
How would you like to be contacted concerning your care (text/call/email)? _____
Whom may we thank for referring you? _____
Name of Primary Care Physician: _____ND, MD, APRN (circle one)
Date of last physical:_____ Permission to contact for medical records_____

CURRENT HEALTH CONCERNS

Please list, in order of importance, your chief concerns:
1. _____
2. _____
3. _____
4. _____
What are your current symptoms? _____
When did they begin? _____
What brought on your symptoms? _____
Have you had any treatment for these symptoms? _____
What aggravates your pain (circle all that apply)?: sitting getting up from sitting standing walking running rolling over in bed twisting bending lifting reaching computer work driving coughing/sneezing neck movements sleeping other_____
What relieves your pain (circle all that apply)?: sitting standing walking lying down stretching cold heat other_____
What activities are difficult to perform?: yard work household chores other_____

Circle the least and most amount of pain (0 is least 10 is most)
Circle levels of low back pain: 0 1 2 3 4 5 6 7 8 9 10
Circle levels of neck/upper back pain: 0 1 2 3 4 5 6 7 8 9 10
Circle levels of arm or leg pain: 0 1 2 3 4 5 6 7 8 9 10
Circle levels of headache: 0 1 2 3 4 5 6 7 8 9 10
Symptoms are (circle one): constant intermittent

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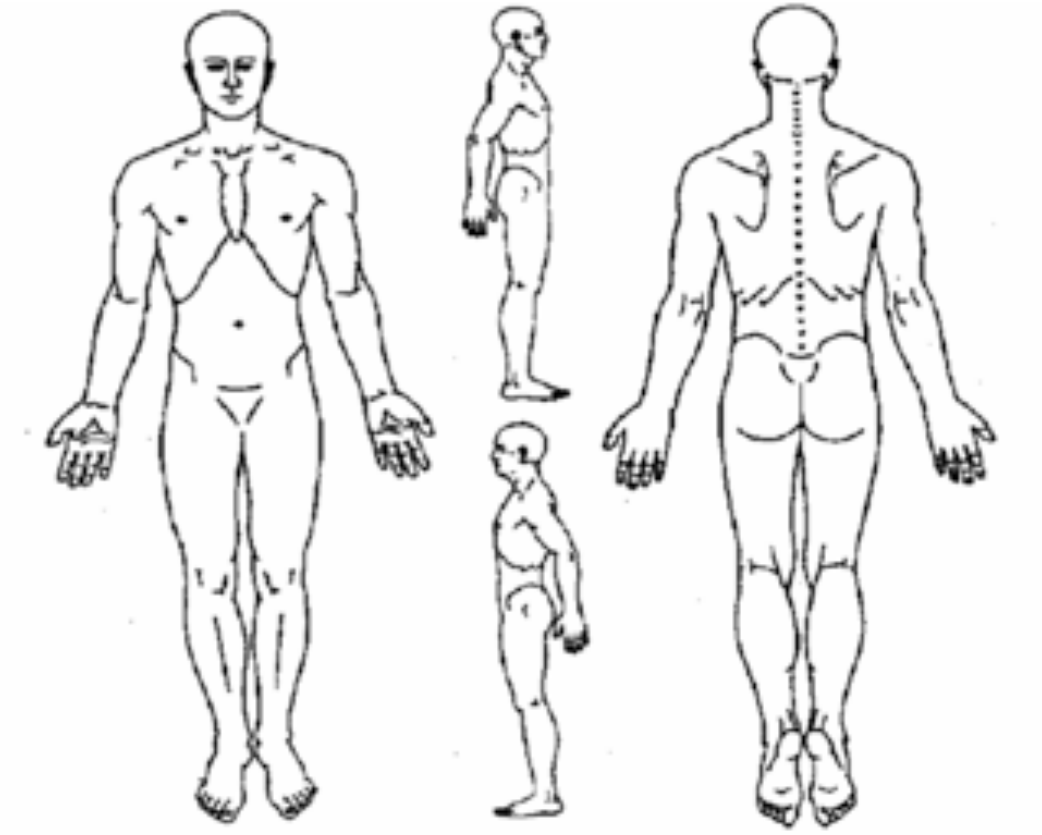
Pain Diagram

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗



MEDICAL HISTORY

Please check if you have experienced any of the following and indicate when.

_____Allergies	_____Arthritis	_____Asthma/Sinus
_____Auto Accident	_____Autoimmune Disease	_____Cancer
_____Diabetes	_____Digestive Problems	_____Heart Disease
_____High Blood Pressure	_____HIV	_____Kidney Disease
_____Multiple Sclerosis	_____Neuritis	_____Prostate Disease
_____Scoliosis	_____Seizures	_____Serious Injury
_____Stroke	_____Ulcers	_____Venereal Disease
_____Other		

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How many pregnancies? ___ Live births? ___ Any significant problems with conception, gestation, delivery or post-partum?_____
_____
Are you pregnant? _____ Date of last menstrual period?_____
List major childhood illnesses: (ear infections, strep throat, tonsillitis, chicken pox, measles, etc.)_____
Have you ever been to a chiropractor before?_____
Name of chiropractor _____Last visit _____

Please list hospitalizations, surgeries, major accidents/injuries, x-rays, CAT scans, MRIs, EKGs, etc.
Year: _____ Description: _____
Year: _____ Description: _____
Year: _____ Description: _____
Year: _____ Description _____

Major mental/emotional traumas: (loss of loved one, divorce, career change, miscarriage, major disease, etc.)_____
List any real or suspected allergies/sensitivities to drugs, food, alcohol, caffeine, chemicals, perfumes, smoke, environment, or other:_____
_____
How were they diagnosed and by whom?_____
Do you drink alcohol?_____ If so, how often?_____
Do you smoke?_____ If so, how many packs per day?_____

Please list your current medications and supplements.
_____ _____
_____ _____
_____ _____

Height: _____ Weight: _____

Categorize the following habits as good, fair or poor
Bowel Regularity _____ Diet _____
Energy Exercise/Activity _____ Mood _____
Sleep _____ Water Intake _____

FAMILY HISTORY

Please list immediate family members who have the following conditions:

Autoimmune disease:_____ Cancer:_____
Diabetes: _____ Heart disease: _____
Stroke: _____ Other: _____

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CONSENT FOR TREATMENT

It has been determined that your condition would benefit from one or more of the treatments listed below.

___**Chiropractic manipulation:** a high velocity and low amplitude technique designed to mobilize restricted joints in the spine and extremities. Please identify any areas you do not want manipulated.

___**Muscle energy technique/mobilization:** gentle mobilizations for restricted joints.

___**Soft Tissue work:** gentle massage to release tight muscles, fascia, and trigger points.

___**CranioSacral therapy:** gentle hands-on therapy to relieve deep body tension, pain and dysfunction.

___**Stretching:** used to elongate tight muscles.

___**Exercises:** palliative or strengthening exercises demonstrated in office for home use.

___**Homeopathic Supplements/Bach Flower Remedies**

___**Nutritional/lifestyle counseling**

Potential Benefits: Benefits from the treatments above can include pain relief, increased range of motion, and return to activity.

Potential Risks: As with any health care procedure, adverse reactions may occur including:

- Short-term aggravation of symptoms of muscle and ligament pain.
- Although uncommon, rib fractures have been known to occur following manual therapy.
- There are reported cases of stroke associated with visits to chiropractors and primary care doctors. The most current research indicates a temporal relationship between the occurrence of a stroke and a preceding visit to either a chiropractor or a primary care physician. You are being informed of this reported association because strokes can result in serious neurological impairment or death. The incidence of stroke associated with cervical manipulation is exceedingly rare and are estimated to occur between one in 1 million and one in 5 million adjustments.
- When nutritional, lifestyle, or any ancillary recommendations are suggested by your health care provider to enhance the healing process, material risks will be discussed on an individual basis.

Alternatives to chiropractic treatment: There are other treatment options that may benefit your condition. The major alternatives to chiropractic care include: physical therapy, massage, acupuncture, physiatry, orthopedic or neurosurgery, or psychological counseling. In some cases, neuromusculoskeletal conditions will resolve with no treatment.

I recognize that even the gentlest therapies may potentially have complications in very young children, in the elderly, or in those on multiple medications. Hence, the information I have provided my health care providers is complete and inclusive of all health concerns and medications, including over-the-counter medications, supplements, and herbs I may be taking.

I have read and understood the above explanation of chiropractic manipulation and related treatment. I have discussed it with Sharon A. Vallone, DC FICCP or Faraneh Carnegie-Hargreaves, DC and have had my questions answered to my satisfaction. I hereby give my written consent for evaluation and treatment. I intend this as a consent form to cover my entire course of treatments including any future conditions for which I seek treatment.

_____	_____	_____
Printed Name	Signature	Date

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SUMMARY OF NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will use and disclose your health information in order help you obtain payment for our services by allowing insurance companies to process insurance claims for services rendered to you by us or by other health care providers. Finally, we may disclose your health information for certain limited operational activities such as assessment, licensing, accreditation, and training of students.

Uses and disclosures based on your authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information, social security numbers or other financial information without your written authorization.

Uses and disclosures not requiring your authorization. In the following circumstances, we may disclose your health information without your written authorization.

- To family members or close friends who are involved in your health care.
- For certain limited research purposes.
- For purposes of public health and safety.
- To government agencies for purposes of their audits, investigations and other oversight activities.
- To government authorities to prevent child abuse or domesKc violence.
- To the FDA to report product defects or incidents.
- To the law enforcement authorities to protect public safety or to assist in apprehending criminal offenders.
- When required by court orders, search warrants, subpoenas and as otherwise required by law.

Patient Rights. As our patients you have the following rights:

- To have access to and/or a copy of your health information.
- To receive an accounting of certain disclosures we have made of your health information.
- To request that we communicate with you in confidence.
- To request that we amend your health information.
- To receive a notice of our privacy practices.

A COPY OF THE COMPLETE NOTICE IS AVAILABLE UPON REQUEST.

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, _____,
hereby acknowledge that I have been provided with a copy of the Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access that information. I understand that if I have questions or complaints, I may contact: **Sharon A. Vallone, DC, FICCP or Faraneh Carnegie-Hargreaves, DC at 860.432.9923.**

I also understand that I am entitled to receive updates upon request if this office amends or changes its Notice of Privacy Procedures in a material way.

_____ _____
Signature Date

Relationship to Patient, if signed by someone other than the patient.

_____

This section is to be completed by our office, if unable to obtain written acknowledgement from patient.

I made a good faith effort to obtain written acknowledgement of receipt of the Notice of Privacy Practices from the above-named patient, but was unable because:
[ ] Patient declined to sign this written acknowledgement.
[ ] Other (specify): _____

_____ _____
Name and Title of Employee Date

PATIENT RESPONSIBILITIES

I agree to be financially responsible for all charges incurred at this office. I will make payment as required at the time of service. Should collection efforts be necessary to collect money owed, a 15% interest charge will be added to the balance due. I am liable for any cost incurred by Drs. Vallone or Faraneh in collection efforts.

If you are unable to make your appointment, please provide 24 hour notice of cancellation. A cancellation fee will apply for appointments cancelled with less than 24 hour notice.

_____ _____
Signature Date

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND/OR PERMISSION TO DISCUSS MEDICAL HISTORY/RECORDS

PATIENT'S NAME: _____

CONSENT TO RELEASE MEDICAL RECORDS

I consent to the release of my medical records to:
Name:_____

Address:_____Phone:_____

Parent/Guardian Signature:_____Date:_____

Relationship to patient, if signed by someone other than patient_____

CONSENT TO DISCUSS MEDICAL HISTORY/RECORDS

I give Drs. Sharon A. Vallone or Faraneh Carnegie-Hargreaves permission to discuss my medical history/ records with:
Name:_____

Address:_____Phone:_____

Parent/Guardian Signature:_____Date:_____

Relationship to patient, if signed by someone other than patient_____

CONSENT TO SHARE INFORMATION WITH ALL PRACTITIONERS AT KIDSPACE

I have been informed that electronic medical records are shared amongst the practitioners at KIDSPACE, I consent to the sharing of my health care and education information with the other practitioners at the KIDSPACE facility whether co-treating or consulting.

_____ _____
Signature Date

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