INFINITY WELLNESS CENTER
Chiropractic & Acupuncture

Cupping Intake Form

Name:		**Email:**
Address:		
City, State, Zip:	**Date of Birth:**	**Age:**
Home Phone:		**Cell Phone:**
Emergency Contact (Name & Phone):		
Referred by:		**Employer:**
Occupation:		**Marital Status:**
Have you ever had cupping before?		**Chinese herbal medicine?**
Reason for today's visit:		
How long have you had this condition?		**Is it getting worse?**
Does it bother your: ☐ Sleep ☐ Work ☐ Other (What?)		
Is this your first time with this condition?		
What seems to make it better?		**What seems to make it worse?**
Other concurrent therapies?		

INFINITY WELLNESS CENTER
Chiropractic & Acupuncture

Cupping Informed Consent

Massage Cupping is a treatment of creating a vacuum suction in a cup, which is applied to the surface of the skin. The purpose of this technique is to promote health and healing by: loosening soft tissue and connective tissue, scarring and adhesions moving stagnation and increasing lymphatic flow and circulation. The cups are moved over the skin using gliding, shaking, popping, and rotating techniques while gently pulling up on the cup, or may be parked or placed for a short time to facilitate joint mobilization or soft tissue release. Another benefit is to pull toxins and inflammation from the body to the surface of the skin where the lymphatic system can more readily eliminate them.

Potential reactions to Massage Cupping are temporary and may include:

Cupping marks: discoloration due to metabolic waste, toxins and other stagnant material that have been freed from the underlying tissue.

Post treatment tenderness: Usually less than experienced from deep tissue work.

Redness and itching: increased vaso-dilation and/or inflammation brought to the surface

Very rarely a slight burn or blister may appear due to the heat and or suction.

Suggested after care recommendations:

Drink plenty of water to help eliminate toxins out of the body.

Avoid showers, steam, sauna and exercise for 3-4 hours.

Light stretching and range of motion exercises are beneficial.

Exercise the next day will help increase circulation to aid in fading of cup kisses.

Contraindications:

People who are on blood thinners should alert Infinity Wellness Center. People with skin ulcers, high fever, spontaneous bleeding, thin muscles, edema, convulsions, abdominal or sacral regions of pregnant women, severe allergic skin, dermatitis should not receive this treatment. You cannot be under the influence of drugs or alcohol.

Infinity Wellness Center has provided me with information on the Cupping bodywork technique. If I choose to experience this therapy in my treatment, I understand the effects and after-care recommendations. It has been explained to me that there is a possibility of a temporary skin discoloration or “cup kiss”, appearing as tissue is released. I am aware that a “cup kiss” is a form of a bruise and that is will dissipate within a few hours to 14 days.

I understand that all treatments by the practitioner at this facility are therapeutic in nature. I agree to notify the practitioner of any physical discomfort experienced during the session. I have stated all relevant physical conditions and will inform the practitioner of any changes in my health.

_____ **initial:** I hereby give my consent for pictures, videos, and audio to be used for marketing purposes. This includes all services provided by Infinity Wellness Center

Print Name:_____ Date:_____

Signature:_____

AUTHORIZATION FOR CARE

I hereby authorize the doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

Ownership of X-ray Films: *It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negative will*

INITIAL IF READ ABOVE: _____

TERMS OF ACCEPTANCE

When accepting a new client who is seeking chiropractic, A.M.I.T, pulse, Class IV laser, dry needling, cupping, and/or acupuncture, it is essential for both the client and the doctor to be working towards the same objective. Chiropractic has only one goal to work toward the cause, not the effect. It is only when the client understands both the objective and the method that they will be able to attain it. This will prevent any confusion or disappointment.

An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine. Health is a state of optimal physical, mental and social well being, not merely the absence of disease. Vertebral Subluxation is a misalignment of one or more of the joints in the body. This can cause pain or alteration of nerve function and interference of the transmission or nerve impulses, lessening the body's innate ability to maintain maximum health.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I have read and fully understand the above statement. Any questions regarding the doctor's objectives pertaining to my care in this office have been an-

INITIAL IF READ ABOVE: _____

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of you records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- *Conduct, plan, and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly*
- *Obtain payment from third party payers.*
- *Conduct normal healthcare operations such as quality assessments and physician's certifications.*
- *You may request super bill, documentary of visits by email.*

I have read and understood your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict

PATIENT NAME (PLEASE PRINT):	RELATIONSHIP TO PATIENT (if minor):
SIGNATURE:	DATE:

INFINITY WELLNESS CENTER
Chiropractic & Acupuncture