The Webster In-Utero Constraint Technique

Chiropractic care benefits all aspects of your body's ability to be healthy. This is accomplished by working with the nervous system – the conduit of intelligence between your brain and body. Doctors of Chiropractic work to correct subluxations (misalignments) of the individual spinal bones. When subluxation, these bones put pressure on the spinal cord and spinal nerves causing malfunction in any part of the body.

Dr. Larry Webster, founder of the International Chiropractic Pediatric Association developed the Webster Technique as a safe means to restore proper pelvic structure and function for pregnant mothers.

The Webster technique is a specific chiropractic analysis and diversified adjustment. The goal of the adjustment is to reduce the effects of subluxation and/or sacroiliac joint dysfunction. In so doing, neuro-biomechanical function in the sacral/pelvic region is improved.

The ICPA recognizes that in a theoretical and clinical framework of the Webster Technique in the care of pregnant women, sacral subluxation may contribute to difficult labor for the mother (i.e., dystocia). Dystocia is caused by an adequate uterine function, pelvic contraction, and baby mal-presentation. The correction of sacral subluxation may have a positive effect on all of these causes of dystocia.

In this clinical and theoretical framework, it is proposed that sacral misalignment may contribute to these three primary causes of dystocia via uterine nerve interference, pelvic misalignment in the tightening and portion of specific pelvic muscles and ligaments. The resulting tense muscles and ligaments and their aberrant affect on the uterus they prevent the baby from comfortably assuming the best possible position for birth.

Because of the effect the chiropractic adjustment has on all body functions, all pregnant mothers should have their spines checked regularly throughout pregnancy, optimizing health potential for themselves and their developing baby. Yes, chiropractic care from conception and continued after birth for both mother and child is given many families an opportunity for greater health.

CONFIDENTIAL PATIENT INFORMATION FORM

Today's Date:_____

NAME:_____ Home Phone:_____ Work #_____ Cell #_____

Home Address:_____ City_____ Zip: _____ How Long?_____

DATE of BIRTH: _____ AGE: _____ M:___ F:___ Marital Status S M W D # of Children_____

SOCIAL SECURITY #: _____ DRIVER'S LICENSE #:_____

Your Employer:_____ Address:_____ City_____ State/Zip_____

Your Occupation: _____ Spouse's Name:_____ Spouse's Occupation:____

Spouse's Employer:_____ Address:_____

NAME OF PERSON RESPONSIBLE FOR ACCOUNT:_____

Check Which One/If Any that Applies: On the job injury (L&I) _____ or AutoAccident_____

INSURANCE INFORMATION

Name of Insurance Company and Policy #

_____

In Case of Emergency (name of relative or close friend NOT living in your home)
Name:_____Address:_____Phone#:_____

I understand and agree that Health and Accident Insurance policies are an arrangement between an Insurance Carrier and Myself. Furthermore, I understand that Drs. Snyder will prepare any necessary reports and forms to assist me in making collection from the Insurance Company and that any amount authorized to be paid directly to Drs. Snyder will be credited to my account upon receipt. However, I clearly understand that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I agree also, that Drs. Snyder may impose reasonable interest late charges, cost, and/or reasonable attorney's fees should my account become delinquent. I agree that any lawsuit for collection of my account may be brought in Spokane County, Washington.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

PATIENT'S SIGNATURE_____DATE:_____

Terms of Acceptance

When a woman seeks the benefits of the Webster In Utero Constraint Technique and we accept a patient for such care it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of a force to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function. This results in interferences to the transmission of mental impulses, leading to a decrease in the body's overall, healthy performance.

The tense muscles in the pelvis, caused by misalignment in the sacrum may lead to constraint in the uterus. When the uterus is torqued and constrained in this manner, it is more difficult for the baby to move into the best possible position for birth. The Webster Technique is a specific chiropractic adjustment which corrects subluxation in the sacrum. As a result, the mother's tense pelvic muscles and ligaments relax, enhancing the physiological environment needed for normal baby positioning.

We do not offer to diagnose or treat any condition. We are not turning malpositioned babies. We do not determine baby position. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our method is detection of and specific adjusting of vertebral subluxation.

I have read and fully understand the above statements.
All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.
I therefore accept chiropractic care on this basis.

signature _____ date_____

HIPAA NOTICE OF PRIVACY PRACTICES
SUMMARY AND DISCLOSURE
Audubon Park Chiropractic

Effective Date: _____

Our HIPAA Notice of Privacy Practices describes the privacy practices of Audubon Park Chiropractic. We respect our legal obligation to keep health information that identifies you private, and by law, we are obligated to provide you a notice of our privacy practices. We are required by law to maintain the privacy of your health information, to follow the terms of our Notice that are currently in effect, and if you request, to provide you a copy of our Notice regarding our privacy practices and legal duties in respect of you and the information we collect and maintain regarding your health information. Our Notice also describes your rights regarding your health information and certain obligations that mandate how we use and disclose your health information.

Your Rights You may...

-Request to inspect any copy of your records.
-Request to amend incomplete or inaccurate information in your records.
-Receive an accounting of certain disclosures of your health information.
-Ask for additional privacy protections (although your request may be declined).
-Ask for confidential communications in a particular manner.
-Receive a paper copy of this Notice.
-File a complaint without penalty.

Use and Disclosures We will not use or disclose your information unless you tell us to do so or unless the law allows or requires us to do so. We use and disclose your information:

-For treatment, payment, and health care operations.
-Through patient scheduling; to notify family or a close friend you have entrusted with your care; or for notification after benefits and services.
-As permitted or required by the law.
-For certain activities when the law requires it, such as: public health, reporting of abuse, neglect, or domestic violence; health oversight; lawsuits and disputes; law enforcement activities; coroner; medical examiner, or funeral director purposes; organ donation; avoidance of a serious threat to health or safety; workers' compensation; and national security.
-With your authorization.

Changes to this Notice We reserve the right to change this Notice at any time as allowed by law. Updated Notices will be in our office and paper copies will be available upon request.

Complaints If you believe that we have not properly respected the privacy of your health information, you may file a complaint with our clinic by contacting an Office Manager by calling (509) 327-4049, sending a letter to our office address, or by e-mailing twochiros@comcast.net

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Please indicate below if we may discuss your health information, appointment scheduling and/or billing with someone else you trust:

❑ Spouse: _____ ❑ Parent/s or Guardian/s: _____

❑ Relative/Friend/Other: _____ Indicate Relationship: _____

❑ Please do not release my information to anyone unless required to do so by law.

Acknowledgement of Receipt of this Notice As a patient of Audubon Park Chiropractic, I acknowledge that I have received and seen this notice and understand that I may request a copy of the full HIPAA Notice Privacy Practices for additional information. I understand that Audubon Park Chiropractic respects their legal obligation to keep health information private unless required by law. My signature below indicates that I agree to these conditions.

Printed Patient Name: _____

Signature of Patient _____ Date _____
(Parent or Guardian Signature if Patient is a Minor)