Informed Consent For Chiropractic Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below.

I have had an opportunity to discuss with the doctor named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations sprains, and strains.

Chiropractic treatment involves the science, philosophy and art of locating and correcting spinal misalignments and is oriented toward improving spinal function relative to range of motion, muscular and neurological aspects. We as chiropractors do not diagnose illnesses or treat disease. Chiropractors correct spinal misalignments which allow the body to function to it greatest capacity

There has been no promise, implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this clinic. I understand that the chiropractor will use his/her hands or a mechanical device upon my body to adjust a joint, which may cause an audible "pop" or "click." Neither the practice of chiropractic or medicine is an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgment and expertise in working with like cases.

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment; a means of communication among other health professionals who may contribute to my care; a source of information for applying my diagnosis and treatment information to my bill; and a means by which a third-party payer can verify that services billed were actually provided. By signings below I hereby authorize my insurance company/administrator to pay by check, and for it to be mailed directly to Park Bench Chiropractic the expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that the Practice reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided or forward a copy in via e-mail at my request. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Practice has already take action in reliance thereon.

Elaboration of possible risks associated with chiropractic adjustments:

- **Temporary soreness or increased symptoms or pain**. It is not uncommon for patients to experience temporary soreness or increased symptoms or pain after the first few treatments.
- **Fractures**. When patients have underlying conditions that weaken bones, like osteoporosis, they may be susceptible to fracture. It is important to notify your chiropractor if you have been diagnosed with a bone weakening disease or condition. If your chiropractor detects any such condition while you are under care, you will be informed and your treatment plan will be modified to minimize risk of fracture.
- **Stroke.** While exceedingly unlikely, some research suggests a possible association of chiropractic adjustments to a very rare type of stroke. This type of incident can be reduced by screening procedures.
- **Other risks** associated with chiropractic treatment include rare burns from physiotherapy devices that produce heat, for example a heated pad.

I have read, or have had read to me, this informed consent document. *I have discussed or been given the opportunity to discuss any questions or concerns with my chiropractor and have had these answered to my satisfaction* ***prior to my signing this informed consent document***. I have made my decision voluntarily and freely.

_____ _____

Signature of Patient or Guardian Date Signature of Witness Date

_____, D.C.

Signature of Chiropractor

Date: _____

Please See Other Side for Additional Information →

HIPAA / Privacy & Information Practices

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is **strictly limited** to defined situations that include emergency care, quality assurance activities, and public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operation will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days of a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation. You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you. In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff. You can choose to specify a means of communication that you prefer for privacy or other concerns.

Our practice is required to abide by this notice. We have the right to change this notice in the future so long as it complies with HIPAA regulations. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our Office Manager if you are not satisfied at any time.

The most common type of information sharing our office engages in is for the purpose of billing your insurance company. To do that we must communicate to them the dates of service and type of services provided, as well as information about your condition. This is needed in order to have your insurance company cover your care.

This office also routinely provides primary care physicians or other doctors you already see with information about your treatment at this office. In these instances we fax or send via US postal service information regarding your condition and treatment to these individuals so that they are aware of your chiropractic care and are able to co-manage you with us effectively.

You have the option of asking us to NOT communicate with other health care providers by noting that in the blank space below your signature.

Signature _____

Name _____ **Phone** _____

The effective date of this Notice of Information Practices is November 2013.

Thank You.

Financial Policy Notice & Agreement

Payment is expected at the time of service.

If you have insurance that covers chiropractic care we will bill your charges directly to your insurance company. They will then pay us the portion you are *not* responsible for. **You will be required to pay any deductible, co-pay or co-insurance that is part of your policy.**

If you have a deductible, you will have to pay for your care out-of-pocket until the deductible has been paid for. Unfortunately, your deductible is beyond our control. If we do not collect your deductible, we do not get paid at all for your care. Please be aware that your insurance policy is a contract between you and your insurer and our office has no say in the matter.

If your insurance requires you to attain a referral to have your care paid for, this is the patient's responsibility as outlined in their insurance contract. Any unpaid balances owing to lack of a referral will be billed to the patient.

We will do our best to accurately assess your insurance benefits such as copay amount. However since this is an estimate provided by your insurance company, any balance on your account will be an out of pocket expense.

We do offer affordable cash plans for people without insurance, or those without adequate insurance coverage undergoing financial hardship.

Every patient is fully and personally responsible for any/all fees and charges not covered or paid by the patient's insurer.

The undersigned patient further acknowledges and agrees that any fees not paid in sole or in part is the patient's responsibility.

Your signature below shows that you understand and agree to this financial policy:

IF YOU PAY WITH CHECK AND THE CHECK IS RETURNED FOR
IINSUFFICIENT FUNDS WE WILL PASS THIS FEE PLUS A $30 PENALTY
ON TO YOU AS YOUR RESPONSIBILITY. SORRY!
WE WILL GLADLY HOLD A CHECK IF YOU NEED TO BE SURE IT CLEARS,
LET US KNOW – WE ARE EASY TO WORK WITH!

Print: _____

Sign: _____ Date: _____

Assignment of Benefits

I hereby assign all medical benefits to which I am entitled, including private insurance and any other health plan, to *Park Bench Chiropractic*. A photocopy of this assignment is considered to be as valid as the original. I hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment. I also agree to fully pay Park Bench Chiropractic out of any funds dispersed to me related to this case or my care here.

Patient (or Patient's Legal Guardian) _____ Date: _____