Informed Consent to Chiropractic Treatment

The Nature of Chiropractic Treatment: Chiropractic care is a conservative, effective and safe treatment for most musculoskeletal conditions and certain neuropathies. In most cases, the chiropractic treatment will involve an "adjustment" or "manipulation" of one or more joints of the musculoskeletal system. The doctor of chiropractic will use his/her hands or a mechanical device in order to mobilize specific joints that have been determined to be contributory to your complaint; this is referred to as an adjustment or manipulation. In addition, the chiropractor may use various ancillary and palliative procedures as part of the treatment regime, such as: heat or cold packs; electrical stimulation; therapeutic ultrasound; therapeutic massage or soft tissue techniques.

Possible Risks: As with any health care procedure, complications are possible as a result of a chiropractic manipulation. Complications may include, but are not limited to: fractures of a bone; muscular strain; ligamentous sprain; dislocation of joints; injury to intervertebral discs, nerve tissue, or the spinal cord; stroke (CVA). A minority of patients may experience stiffness, soreness, or an increased level of discomfort within the first few days following a treatment. In addition, the ancillary procedures may produce skin irritation or burns. *Persons that have known medical conditions that may possess unique medical risks, such as a pacemaker, metal implants, or pregnancy, should alert the chiropractic physician to avoid possible complication or injury, as well as death.*

Probability of Injury: The risk of complications due to a chiropractic manipulation is described as "rare". An accurate and complete medical history of the presenting compliant, a thorough physical examination, and the use of radiographic studies when indicated will significantly reduce the risk of injury and ensure the appropriate treatment. The probability of adverse reaction due to ancillary procedures is also considered rare.

Other Treatment Options: *Chiropractic care can be refused at any time.* In lieu of chiropractic care, other treatment options are available. The doctor of chiropractic will discuss the various options, to include specialized diagnostic testing, and when clinically necessary, or upon request, the appropriate referral will be made.

- *Over-the-counter medication: Anti-inflammatory and pain medications.*
- *Medical Care: Physical therapy; Prescription Medication; Surgery.*
- *Acupuncture*

Risks of Remaining Untreated: Failure to treat any medical condition may result in unnecessary and unforeseen complications, injury, or death.

I have read the aforementioned explanation of the chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment at this facility. However, I will expect the physician to exercise professional judgment during the course of treatment which the physicians feels will be in my best interests at the time, based upon the facts then known.

_____

Patient's Signature **Date**

WITNESS:

_____

Signature **Date**

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Burley-Stroker Chiropractic originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, 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 the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

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 I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Burley –Stroker Chiropractic 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 organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Burley-Stroker Chiropractic reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Burley-Stroker Chiropractic change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and ☐ **ACCEPT** / ☐ **DECLINE** the terms of this consent.

_____

Patient's Signature

_____

Date

FOR OFFICE USE ONLY

[ ] Consent received by _____ on _____.

[ ] Consent refused by patient, and treatment refused as permitted.

[ ] Consent added to the patient's medical record on _____.

Patient Billing Acknowledgement Form
Non-Covered Services

Under your health plan, you are financially responsible for Co-Payments, Co-Insurance, and Deductibles for covered services, as well as those services that exceed your benefit limits. **You are also financially responsible for all Non-Covered services as defined by your health plan contract.**

This may include items such as ice packs, heel lifts, orthotics, x-rays, or certain chiropractic therapies.

These services or products listed above may not be covered according to your health plan. Your acknowledgement below indicates that you have been advised of this information and that you agree to pay for the listed services or products if they are deemed non-covered charges by your insurance.

PATIENT

_____, acknowledge that I have been told in
PATIENT NAME-PRINTED OR TYPED

advance by my provider that the services/products listed above may not covered by my Health Plan and that they meet the above definition of non-covered charges. I agree to pay for these non-covered services.

Patient/Guardian Signature **Date**

_____ _____

PROVIDER

Witness Signature: _____