# Clark Road Chiropractic Center

3220 Clark R. Sarasota, FL 32431 P: 941-923-4357 F: 941-923-9943

## INFORMED CONSENT TO TREATMENT

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

**The nature of the chiropractic care.**
The doctors of chiropractic in this office are trained to provide chiropractic adjustments, physiotherapy modalities and received additional training to provide acupuncture therapy. There are various ways these modalities may be applied. Chiropractic care is an alternative and conservative form of healthcare. Although the risks are small, it is our obligation to inform you of them. The doctors will make every reasonable effort during the examination to screen for contraindications to care, however if you have a condition that would otherwise not come to my attention it is your responsibility to inform the doctor prior to treatment rendered.

**The availability and nature of other treatment options.**
Other treatment options for your condition may include:
• Self-administered, over-the-counter analgesics and rest.
• Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and painkillers
• Hospitalization
• Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

**The risks and dangers attendant to remaining untreated.**
Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

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 and sprains. In addition, acupuncture treatment involves risks such as forgotten needles, bruising, or slight bleeding. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. I understand that the doctor is not providing (allopathic) medical care, and that I should look to my primary care practitioner (i.e. MD) for those services and for routine check-ups.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the licensed doctor of chiropractic who now or in the future work at the clinic or office listed above.

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.**

*****PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW*****

**I have read ☐ or have had read to me ☐ the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. I hereby give my consent to that treatment.**

PATIENT'S NAME (print): _____ Date of Birth: _____/_____/_____

Name of person authorizing treatment of MINOR or DEPENDANT (print): _____

PATIENT/GUARDIAN'S SIGNATURE: _____ DATE: ____/_____/_____| 1

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## ***REQUIRED***: CONFIDENTIAL PATIENT HEALTH RECORD

(Please print)

NAME: _____

Date of Birth: ____/____/____ AGE_____

ADDRESS: _____

_____

SOCIAL SECRUITY #: _____-_____-_____

EMERGENCY CONTACT: _____

PHONE: ( ) _____

PRIMARY PHONE: ( )_____ M H W

***For text message reminders please provide your *Cell Carrier*: (AT&T) (VERIZON) (T-MOBILE) _____

EMAIL: _____

*Your email will be enrolled into our patient portal. Check ☐ to opt out

EMPLOYER: _____

OCCUPATION: _____

HOW DID YOU HEAR ABOUT US?_____

CURRENT PROBLEM/ COMPLAINTS: _____

_____

_____

***IS THIS VISIT DUE TO AN ACCIDENT?*** -Yes- -No- DATE OF INJURY: _____/_____/_____

ATTORNEY'S NAME: _____ PHONE: ( ) _____

**Personal Demographics**:

Gender: -M- -F- Height: _____ Weight: _____ Marital status: _____# of children: ____

Smoking Status **(circle)**: - Current - Occasional - Past - Never-

Do you drink Alcohol? - YES- -NO- Do you drink Coffee? - YES- -NO-

SIGNIFICANT HEALTH HISTORY: _____

CURRENT MEDICATIONS: _____

Are you allergic to any medications? _____

PRIMARY PHYSICIAN: _____ PHONE NUMBER: ( )_____

Other doctors you see (OB, Neurologist, orthopedist, etc.): _____

TREATMENT YOU ARE SEEKING: (check all that apply) ☐ CHIROPRACTIC ☐ ACUPUNCTURE ☐ MASSAGE

☐ A.R.T. ☐ ORTHOTICS ☐ PAIN MANAGEMENT ☐ REHABILITION ☐ NUTRITIONAL COUNSELING

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

People go to chiropractors for a variety of reasons and there are different levels of care.
Please check the type of care desired so that we may provide you the most appropriate management:

**STAGE 1 ____ Pain relief:** just get rid of the pain. Relief is short term.
**STAGE 2 ____ Rehabilitation**: get rid of the pain, but then fix the problem so it won't come back.
**STAGE 3 ____ Optimal health**: get rid of the pain, fix the problem, and then put me on a preventive maintenance plan so that I stay as healthy as possible.

***"Thank you for your help in understanding as we try to maintain a complete and accurate record of your medical information. You are welcome to a copy of this data at any time. If you have any questions regarding this information, please let us know. "***

PATIENT'S NAME (print): _____ Date of Birth: _____/_____/_____

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PATIENT/GUARDIAN'S SIGNATURE: _____ DATE: ____/_____/_____

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**REVIEW OF SYSTEMS -** "Check the box if you have or have had trouble with any of the following. Leave blank if not applicable"

| **GENERAL** | **Past** | **Present** | **HEENT** | **Past** | **Present** | **SKIN** | **Past** | **Present** |
|---|---|---|---|---|---|---|---|---|
| Lethargy/Weakness | | | Headaches | | | Rashes/Itch | | |
| Weight Loss | | | Migraines | | | Flushing | | |
| Pain while Sleeping | | | Vision Problem | | | Excess Acne | | |
| Weight Gain | | | Nose Bleeds | | | Eczema | | |
| Recurring Fever | | | Sore Throat | | | Psoriasis | | |
| Chills | | | Hoarseness | | | Skin Cancer | | |
| **CARDIOVASCULAR** | **Past** | **Present** | Swollen Glands | | | Color Change | | |
| Chest Pain/Pressure | | | Sinus Trouble | | | Nail Changes | | |
| Heart Attack | | | Diff Hearing | | | **GASTROINSTEINAL** | **Past** | **Present** |
| Shortness of Breath | | | Dental Problem | | | Loss of Appetite | | |
| Palpitations | | | TMJ Problems | | | Nausea/Vomiting | | |
| Swelling of the Feet | | | **RESPIRATORY** | **Past** | **Present** | Diarrhea | | |
| Hypertension | | | Chronic Cough | | | Constipation | | |
| High Blood Pressure | | | Asthma | | | Abdominal pain | | |
| High Cholesterol | | | Short of Breath | | | Ulcers | | |
| Heart Murmur | | | Exercise Intolerance | | | Bloating/Cramping | | |
| Blood Clots | | | Sleep Apnea | | | Heartburn/Reflux | | |
| Pacemaker | | | Emphysema | | | Hemorrhoids | | |
| Atrial Fibrillation | | | Pneumonia | | | Hepatitis | | |
| Aneurysm | | | **MUSCULOSKELETAL** | **Past** | **Present** | Cirrhosis | | |
| **NEUROLOGIC** | **Past** | **Present** | Arthritis | | | Incontinence | | |
| Frequent Headaches | | | Rheumatoid Arthritis | | | **BLOOD/LYMPH** | **Past** | **Present** |
| Migraines | | | Joint Pain/Swell | | | Anemia | | |
| Dizziness | | | Neck Pain | | | Bleeding | | |
| Fainting | | | Lower Back Pain | | | Bruising | | |
| Memory Loss | | | Osteoporosis | | | Past Transfusions | | |
| Poor Balance | | | Scoliosis | | | Leukemia | | |
| Numbness/tingling | | | Muscle Cramping | | | Lymphoma | | |
| Muscle Weakness | | | **ENDOCRINE** | **Past** | **Present** | HIV/AIDS | | |
| Seizures | | | Diabetes | | | Sickle Cell | | |
| Stroke | | | Thyroid Problems | | | **URINARY** | **Past** | **Present** |
| Tremors | | | Sweating | | | Painful Urination | | |
| Head Injury | | | Hot/Cold Intolerance | | | Excess Urination | | |
| **PSYCHIATRIC** | **Past** | **Present** | Weight Loss | | | Incontinence | | |
| Insomnia | | | Weight Gain | | | Urgency | | |
| Diff Concentrating | | | Excess Urination | | | Kidney Stones | | |
| Memory Loss | | | Excess Thirst | | | ALLERGIES | | |
| Depression | | | Appetite Changes | | | Seasonal | | |
| Anxiety | | | **FEMALE** | **Past** | **Present** | **MALE** | **Past** | **Present** |
| Agitation/Irritable | | | Menstrual Irregularity | | | Testicular Pain | | |
| | | | Hot Flashes | | | Prostate Disease | | |
| | | | Breast Lumps | | | | | |
| | | | Menopause | | | | | |

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## SIGNATURE ON FILE

- I understand that I am ultimately responsible for my bill
- I authorize use of this form on all my insurance submissions
- I authorize release of information to all my insurance companies
- I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies
- I authorize direct payment to my doctor
- I permit a copy of this authorization to be used in place of the original

## HMO/PPO LIMITATION IF LIABILITY

Your insurance plan may have limitation for services covered in our office. According to your specific plan, the following services may not be covered:

*Examinations *Re-evaluations *Hot/Cold Packs *Ultrasound *Massage Therapy
*X-rays *Advanced diagnostic imaging *Acupuncture *Rehabilitation Therapy
*Electric Muscle stimulation *Vitamins/ Supplements *Orthotics/ DME

Should any of these determinations be made by your plan, you agree that you have been informed before the services were rendered and you agree to be responsible for payment of the specific services listed above

***Insurance Benefit Disclaimer:*** "A quote of benefits and/or authorization does not guarantee payment. Final determination will be made once claims are processed by your insurance company. Payment of benefits are subject to all terms, conditions, limitations and exclusions of the member's contract at the time of service

## FINANCIAL POLICY

In order to receive the best care possible within your benefits, it is important that you comply with our financial policy:

1. Payment is expected at the time of service in the form of a deductible, co-payment, or co-insurance payment. * IT IS ILLEGAL TO DISCOUNT THESE FEES*
2. Your insurance policy is a contract between you and the insurance company, and you are responsible for any unpaid or denied claim, and for any collection fees, court costs, and attorney's fees if your account is turned over for collection.
3. If your insurance company sends you checks, it is your responsibility to deliver them to our office.

"I hereby authorize you to furnish information to my insurance company concerning my care. I further hereby assign all insurance payments for services rendered to me or my dependents".

***My signature below indicates that I have read and, understood and comply with the SIGNATURE ON FILE, HMO/PPO LIMITATION OF LIABILITY AND FINACIAL POLICY.***

PATIENT'S NAME (print): _____ Date of Birth: _____/_____/_____

Name of person authorizing treatment of MINOR or DEPENDANT (print): _____

PATIENT/GUARDIAN'S SIGNATURE: _____ DATE: ____/_____/_____| 4

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## ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

*We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. This form will be retained in your medical records.*

I acknowledge that I have received and had the opportunity to review the Notice of Privacy Practices on the date below and on behalf of Clark Road Chiropractic Center.

I understand that the Notice describes the uses and disclosure of my protected health information by Clark Road Chiropractic Center and informs me of my rights with respect to my protected health information.

My signature below stands proof that I give Clark Road Chiropractic Center my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Notice of Privacy Practices.

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**FOR OFFICE USE ONLY**

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

- Patient refused to sign
- Due to an emergency situation it was not possible to obtain acknowledgement
- Communication barriers prohibited obtaining acknowledgement
- Other (please specify): _____

Employee Name (print): _____

Employee Signature: _____ Date: ___/_____/_____

PATIENT'S NAME (print): _____ Date of Birth: _____/_____/_____

Name of person authorizing treatment of MINOR or DEPENDANT (print): _____

PATIENT/GUARDIAN'S SIGNATURE: _____ DATE: ____/_____/_____