Complete Chiropractic of Union – 37 St. Andrews Drive – Union, MO 63084

Informed Consent -- Chiropractic Care

Megan Goss, DC

Patient's Name: _____

Instructions: This document relates to your Informed Consent for care. Please read carefully before signing.

General. I, the below-signed patient/individuals, have read this document and in its entirety and understand the potential benefits and risks of the Care which you are recommending. I understand that there may be other forms of care which I may wish or need to seek provided by other health care practitioners. I also understand that there may be significant risks of not seeking any care for my condition.

I understand that while the Care Plan lists you as the "Rendering Provider," at any moment, other associates or staff in your office with appropriate scopes of practice and training may need to provide the Recommended Care based on factors which are not necessarily within anyone's ability to predict. You have made it clear that every health care practitioner who is licensed under state law may have different scopes of practice relating diagnoses and treatment and that the licenses of the primary Rendering Provider are listed below.

I do not expect you to be able to anticipate and explain all risks and complications, or forms of treatment, and I wish to rely on you to exercise judgment within your scope of practice during the course of the Care Plan which you feel at the time based upon the facts known. I understand that in rare cases, underlying physical defects, deformities or pathologies may render me susceptible to injury. It is my responsibility to make known before and throughout the Care whether I am suffering from any latent pathological defects, illnesses, or deformities that would otherwise not come to your attention, as well as any pathological defects, illnesses, or deformities I may be experiencing.

Possible Risks of the Care; Alternatives

The Nature of the Chiropractic Adjustment

The primary treatment used at the practice is spinal manipulative therapy. It is likely that spinal manipulative therapy will be used as part of your treatment. Spinal manipulative therapy includes use of the doctor's hands and mechanical instruments upon your body in such a way as to mobilize your joints. This movement may cause an audible "pop" or "click", such as experienced when you "crack" your knuckles. You may also feel a sense of movement.

The Material Risks Inherent in the Chiropractic Adjustment

All patient care, including chiropractic treatment, has the potential for negative effects. The risks associated with chiropractic treatments include, but are not limited to, dislocations and sprains, disc injuries, fractures, and strokes. These negative effects are very rare and will be fully explained by your doctor after examination has been completed and a treatment plan has been developed. Another more common side effect is some soreness or stiffness following the treatment. Ice may be used to reduce the discomfort. Your doctor will formulate a treatment plan and will recommend what they fee l is in your best interest.

The Probability of Those Risks Occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which your doctor looks for during your initial consultation your examination and while reviewing our x-rays. Stroke has been the subject of tremendous

disagreement. The incidence of a stroke is exceedingly rare and is estimated to occur between one in one million and one in five million adjustments of the neck. The other complications are also generally described as rare.

Kinesiotape

Kinesiotape is a taping procedure used to reduce local inflammation, restrict muscle contraction or facilitate muscle contraction. The adhesive in the tape may cause a local itching or redness reaction. Peel tape off if this reaction occurs and report this reaction to your provider at the next visit. Direct heat should not be applied to the tape, such as in a sauna or a blow-dryer. Peeling, rather than ripping the tape off is advised. The tape will adhere for 3-4 days.

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 & prescription drugs as anti-inflammatory, muscle relaxants & pain killers.
- Physiotherapy
- Hospitalization, Physiotherapy or Surgery
- 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 physician

The Risks and Dangers Attendant to Remaining Untreated

Remaining untreated may allow the formation of adhesions and reduce mobility of your joints which may set up a pain reaction further reducing mobility. Over time this process may compromise your recovery making treatment more difficult and less effective the longer it is postponed.

Contraindications to Manipulation / Adjustment. I understand that you will not give me an adjustment / manipulation, x-rays, modalities, or therapies if you feel that such are contraindicated. In the event that the Care does not include such procedures, I have discussed all contraindications with you and fully understand them.

Definitions. "You" and "office" refer to any provider who renders care to me at the Location above. "Care" includes all care outlined in my Care Plan as well as any other care I receive from you in the future, including care related to other conditions.

Patient's Consent. I have thoroughly discussed and reviewed my recommended Care with you, as well as your examination, diagnoses, and thoughts regarding my condition, and also all of the information in this Informed Consent. I have had ample opportunity to explore other potential forms of care, have asked you all of the questions that I have, and have no additional questions. I voluntarily and knowingly elect to receive the recommended Care.

Patient's Signature: _____

Patient Name: _____

Date of Signature: ___/___/___

PATIENT CONSENT FORM

Regarding the Use & Disclosure of Protected Health Information

("Consent Form")

For the purposes of this Consent Form, "Office" shall refer to: Complete Chiropractic of Union.

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled, "Our Privacy Practices." I understand that I may review this privacy notice at any time prior signing this form.

I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this Consent in, but only to the extent that the Office has not taken action in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

I authorize Office to leave messages regarding my treatment; including lab results, xrays, information pertaining to my treatment and/or office updates by the following method (please circle Yes or No):

Yes No Home answering machine: _____ **Yes No** Work Voicemail: _____
Yes No Cell Phone/Voicemail: _____

I authorize Office to release any information regarding my treatment; including lab results, x-rays, names(s) of medication(s), information pertaining to my treatment and/or office updates. This includes leaving message(s) on the designated contact(s) phone number. Office may not release information to the named individuals and or entities unless you identify them below.

Name:_____ Relationship to Patient:_____ Contact Info:_____

Name:_____ Relationship to Patient:_____ Contact Info:_____

Name:_____ Relationship to Patient:_____ Contact Info:_____

Name:_____ Relationship to Patient:_____ Contact Info:_____

Office will use my primary phone number and primary address supplied during registration to contact me regarding my treatment; including lab results, x-rays, and information pertaining to my treatment and/or office updates. I will ensure this information is up to date at every visit.

Patient Name (please print): _____

Signature: _____ Date: ___/___/___

Direct Assignment of Benefits
& Authorization to Release Information
(Benefits are Payable Directly to Provider)

Patient Name: _____

Policy Holder's Name: _____

Relationship to Policy Holder: ___Self____ Spouse_____Child_____

Policy Holder's Date of Birth: _____ /_____ /_____

Insurance Company and ID #: _____

My signature below signifies my authorization to release any information pertaining to my case to any authorized insurance representative, or if applicable, any attorney representing me.
My signature below authorizes benefits to be paid directly to:

Complete Chiropractic of Union
37 St Andrews Drive
Union, MO 63084
Phone: 636-583-0700 Fax: 636-583-0799

This is a direct Assignment of Rights and Benefits under this policy.

A photocopy of this shall be considered as valid as the original document.

Patient Signature:_____

Signature of Witness: _____

Date signed: _____

Fee for Services Schedule

Initial Consultation (15 min)	No Charge
Chiropractic Exam	$ 55 – 90
Re-exam	$ 20
1-2 Region Adjustment	$ 35
3-4 Region Adjustment	$ 50
5 Region Adjustment	$ 70
Muscle Therapy	$ 15
Extremity Adjustment	$ 20
Intersegmental Traction	$ 10
Returned check fee	$ 15
Sports/Employment Physical	$ 25

CASH

1. All patients are on a cash basis until their respective insurance coverage and deductible may be verified by our staff. Payment is expected in full unless otherwise discussed.

2. This office may make payment plan arrangements on an individual basis. Any such plan or arrangement will be discussed during your report of findings.

INSURANCE

1. If you have insurance, we will gladly accept assignment with the following exceptions and regulations provided that we have prior certification from your insurance company.

2. We accept assignment for the initial treatment plan only. Any follow-up visits will be payable when services are rendered. Once you have been discharged from active care and placed on maintenance care, we will continue to file your insurance but require full payment each visit.

3. If we are out-of-network, we bill your insurance as a courtesy to you. Your bill is expected to be paid in-full. Any dispute of payment is between you and your insurance carrier, as we have no contract with them.

4. If we are in-network, we will do our best to estimate your portion of the bill due. There are many factors that determine chiropractic coverage, and it is the insurance company that determines the coverage, if any. Occasionally, this office underestimates the patient's portion due, resulting in a balance on your account. Should this happen, you will be notified via mail. This balance is expected to be paid in full as soon as possible.

5. If you should receive a check from your insurance company during our billing, please bring it into the office or call us upon receipt. Occasionally, the insurance company pays the patient instead of the office. If any over-payment exists after all insurance billing has been done, we will issue you an overpayment check – it will not come from your insurance company. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due.

6. Any services not covered or coverage reductions by your insurance will be the patient's responsibility.

7. If the patient is referred to another specialist or discontinues care for any reason other than discharge by the doctor, the bill is due and payment in full expected immediately regardless of any claims submitted.

8. If you have questions concerning this or any other matter, please speak with the receptionist or our insurance department prior to seeing the Doctor.

I have read and understand the Financial Office Policy and agree to abide by these terms.

Patient Name _____ Patient's Signature _____ Date _____

Missed/Late Appointment Policy

We want to thank you for choosing us as your health care provider. In order to give you and all our patients the best possible care, we request that you review our policy regarding missed appointments.

A missed appointment is when you fail to show up for an allotted appointment time, without a phone call or cancellation notice of at least 24-hours. Please remember that we have reserved appointment times especially for you. Therefore, we request at least a 24-hour notice in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients.

If you are unable to keep your scheduled appointment time, please call our office at least 24-hours in advance in order to avoid a missed appointment fee. Your phone call is critical in helping us provide continuous care to all of our valued patients. **If you fail to give us notice of your missed appointment, you may be charged a $25 missed appointment fee.** This charge is not covered by insurance.

Additionally, it is important that you help us stay on time by being here on-time for your appointment. If you are more than 15 minutes late, we will do our best to fit you in, but we may need to reschedule you. We understand emergencies will happen, but please be courteous of other patients and notify us if you know you will be late.

I have read and understand the policy stated above:

_____

Patient Name

_____ _4/4/2017_____

Patient Signature Date