Informed Consent for Chiropractic Treatment

TO THE PATIENT: *You have a right to be informed about your condition, the recommended chiropractic or acupuncture treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.*

I request and consent to chiropractic adjustments and other chiropractic or acupuncture procedures, including various modes of physical therapy and diagnostic x-rays. The chiropractic or acupuncture treatment may be performed by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic working at this clinic or office. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic named below.

In the treatment room I will have the opportunity to discuss with the Doctor of Chiropractic, my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.

I understand that, there are some risks to chiropractic treatment including, but not limited to: broken bones, increased symptoms and pain, dislocations, no improvement of symptoms or pain, sprains/strains, infection (acupuncture), burns or frostbite (physical therapy), punctured lung (acupuncture), worsening/aggravation of spinal condition.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

I have read, or have had read to me, the above consent. I will also have an opportunity to ask questions. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment at Ravenna Chiropractic & Acupuncture.

To be completed by the patient:

_____
print name

_____
signature of patient

_____
date signed

To be completed by the patient's representative:

_____
print name of patient

_____
print name of patient's representative

_____
signature of patient's representative

as: _____
relationship/authority of patient's representative

_____
date signed

RAVENNA CHIROPRACTIC & ACUPUNCTURE
Bill Blueter, D.C. / Tyler Chiplinski, D.C.
6693 N. Chestnut Rd., Suite 128 Ravenna, OH 44266
330-297-9797

SIGNATURE ON FILE

Do you have insurance: Yes ❒ No ❒

If yes, what kind of insurance do you have? _____

I authorize use of this form on all my insurance submissions.

I authorize release of information to all my insurance companies.

I understand that I am responsible for my bill.

I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.

I authorize payment directly to my doctor.

I permit a copy of this authorization to be used in place of the original.

Name _____ *Medicare #* _____

(Please print)

*Patient's Signature:*_____ *Date:* _____

PRACTICE'S REQUIREMENTS

The Practice:

a) Is required by federal law to maintain the privacy of your PHI and to provide you with the Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
b) Under the Privacy Rule, may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.
c) Is required to abide by the terms of the Privacy Notice.
d) Reserves the right to change the terms of this Privacy Notice and to make the Privacy Notice provisions effective for all of your PHI that it maintains.
e) Will distribute any revised Privacy Notice to you prior to implementation.
f) Will not retaliate against you for filing a complaint.

This Notice is in effect as of 04/15/2003

PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

_____ _____

Patient's Signature *Date*

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