Informed Consent for Care

Print Full Name: _____ Date: _____/_____/_____

Chiropractic Manipulation, massage therapy, and traction-based therapy with decompression as a goal of treatment are the services delivered at this clinic. These are not methods for preventing, diagnosing, treating, healing or curing symptoms, disease or medical conditions of any kind. I understand that should I receive chiropractic manipulation, exercise advice or nutritional advice, there may be temporary side-effects such as fatigue and possible aggravation of the symptoms presented after a treatment.

I also understand that being well fed and hydrated is necessary to facilitate benefits from our services and it is my responsibility to see that I have adequate nourishment each day.

I understand the practitioners are Chiropractors and Massage Therapists, and there is no medical care provided of any kind. No cures are guaranteed. I understand that the initial visit includes a history, exam and testing as directed in order to evaluate if the services of the Center are right for me and determine if I am eligible for our services.

I understand that Gregory Wilson, DC, ICCSP will see me my first visit upon request, depending on the reason for appointment. Dr. Wilson performs chiropractic adjustments and physiotherapy procedures including spinal decompression, therapeutic exercises, and Class IV laser.

I understand that once nutritional supplements, essential oils, and any other product are purchased from and leave the office, they may not be returned, exchanged, refunded or credited unless Dr. Wilson determines that the order was filled incorrectly.

Should I opt to take advantage of it, I understand that the discounted, flat rate Pre-Pay Package offered is a non-refundable program and may not be altered, shared, transferred or combined with any other promotional special or discount. I understand that any unused portion of a Pre-Pay Package upon discharge from the above centers may be applied to product purchases or may be moved to another service (excluding complimentary visits that were issued as part of package rate) or is forfeited. I understand that I am free to pay in full, visit by visit and that any prepaid package program is only an incentive to move through my program to achieve my goals.

I understand that Gregory Wilson, DC, ICCSP is paid in cash at the time of service (or in advance with discounted, pre-pay programs) for product purchases. Postdated payments are accepted when proper arrangements are made.

I have read and understand the above terms of service. **Patient Signature _____**

CONSENT TO TREAT A MINOR (Under 18 years old)

I, _____, do hereby request Dr. Wilson to evaluate and perform services for my child named_____, age _____, and consent on his or her behalf. I am a legal guardian of this child. I understand that while this child is in the office, he/she is to be with me at all times and may not be left alone, unsupervised or in the care of staff or other clients. I have read and agree to the Center's above terms.

Guardian Signature _____ Date _____

Staff Member _____ Date _____

PATIENT INFORMATION

NAME: _____ DATE OF BIRTH: ____/____/_____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____-_____-_____ *EMAIL: _____

*CELL PHONE: _____-_____-_____ *I consent to receive text reminders of your future appointments

MARRIED: YES____ NO_____ NUMBER OF CHILDREN (if applicable): _____

SPOUSE'S NAME: _____ DATE OF BIRTH:____/____/_____

SPOUSE'S CELL PHONE: _____-_____-_____

IN CASE OF EMERGENCY, NOTIFY (other than spouse):

Name: _____ PHONE:_____-_____-_____

MEDICAL DOCTOR: _____ PHONE: _____-_____-_____

HOW DID YOU HEAR OF OUR OFFICE: _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

The following points are important that you read and agree to in order for you to become a patient at our clinic.

- All services rendered will be considered **cash** until your insurance is verified.
- If you are unable to keep your appointment, we require that you call ahead to cancel so that someone else, if needed, can be put in your appointed time. ***If you do not show up for your appointment without calling to cancel, we reserve the right to charge you for that service.**
- Payment for services rendered that day are due before you leave unless other financial arrangements have been made.

By signing this, I acknowledge that I have read and agree to the above office policies.

I understand and agree that I am ultimately responsible for the balance on my account for any professional services rendered. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Signature: _____ Date: _____/_____/_____

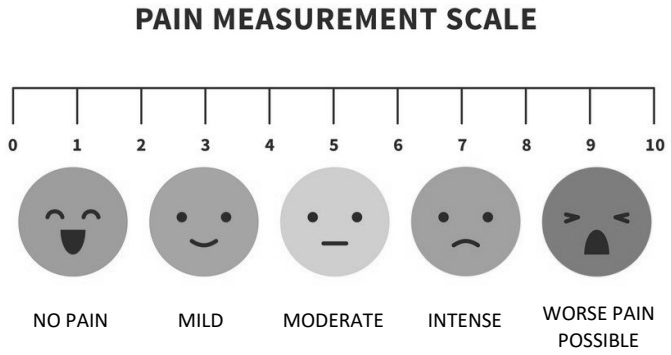
Location of your symptoms and pain scale:

_____ Pain scale: _____

_____ Pain scale: _____

_____ Pain scale: _____

_____ Pain scale: _____



What is the purpose of this appointment?_____

What are your goals with your care? □ PAIN RELIEF □ RESTORE FUNCTION □ STABILIZATION/WELLNESS CARE

Have you ever had the same or similar condition? □ YES □ NO

Please indicate any other healthcare providers who you've seen for this injury or condition.

Name: _____ Type of Practice: MD DC PT Date of Last Visit: ____/____/_____

Name: _____ Type of Practice: MD DC PT Date of Last Visit: ____/____/_____

Is your current condition due to an accident or injury? □ YES □ NO. Date of accident: ____/____/_____

If YES, is it *automobile*? □ YES □ NO *Work related*? □ YES □ NO

Prior surgeries: _____

_____

Current medications: _____

_____

Do you currently have a pacemaker or any other electrical implanted device? □ YES □ NO

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? □ YES □ NO □ UNCERTAIN

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign the consent form (§ 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at anytime for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosures of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to it terms. I am also acknowledging that I have received a copy of this notice.

_____ _____

Printed Name Authorized Provider Signature

_____ _____

Signature Date