Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. **Health** is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a **vertebral subluxation**. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an **adjustment.** An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____ _____ _____

Print Name Signature Date

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

_____ _____

Signature Date

INNER LIGHT CHIROPRACTIC, P.A.
PAYMENT POLICY

The following is an explanation of our office policies. We believe that a clear definition will allow us both to concentrate on the most important issue: regaining and maintaining your health. We will be happy to answer any questions you may have regarding our policies, your account or insurance coverage.

Payment Policy

Regardless of your insurance status or direct personal payment, you are ultimately responsible for the balance on your account for any professional services rendered. Any balance over 30 days will be assessed a 1.5% interest charge compounded monthly and will be added to your account.

There are two forms of payment:

OUT OF POCKET- Payment due every time you come in using CASH, Check or Credit except AMEX -OR-

INSURANCE ASSIGNMENT- Co-pay, coinsurance and insurance reimbursement signed over to our office (explained below)

INSURANCE ASSIGNMENT PROGRAM

It is our desire to assist our practice members whenever possible. The following insurance assignment program allows you, our practice member, to receive the care you need without undue financial strain.

1. Waiting for insurance payment is a courtesy provided by this office. We reserve the right to withdraw this courtesy at any time. We will bill your insurance company and accept assignment of benefits during your initial intensive care period. Direct assignment will be discontinued when you have finished initial intensive care and a supportive health care program is recommended. We will notify you of the change.
2. All deductible amounts must be paid by you in advance of the first billing. Also, you must stay current with your percentage of responsibility. **This must be paid at least weekly**. Prepayments may also be made.
3. The insurance carriers are billed on specific 15-30 day cycles. It's your responsibility to supply this office with necessary forms to complete billing if needed.
4. If you receive payment from your insurance carrier during the period which the clinic has accepted assignment of benefits, you are to bring the check into this office within three days of receipt and endorse it over to the office. Failure to do this may result in collection action.
5. If you discontinue care for any reason other than discharge by the doctor, you will be responsible for any unpaid balance regardless of any claims submitted to your insurance company, at the time you discontinue care.
6. This office does not promise that an insurance company will pay. In the event that the insurance company disputes or rejects the claim, it will be the practice member's responsibility to pay all the charges and pursue reimbursement from the insurance company on his/her own. The insurance company has 30 days from billing days to make this decision. Practice member payment is expected on any fees over 30 days old.

I have read the above provisions and wish to participate in the insurance assignment program. I hereby agree to abide by the provisions as specified above.

_____ _____

Practice Member's Signature Date

OFFICE POLICY

Consent for Care in an "Open" Family Adjustment Environment

I voluntarily consent to the rendering of care, including adjustments and conversations about adjustments and your care in an "Open" family adjustment environment. I understand that the "Open" family adjustment environment refers to a room in which other patients may be adjusted or waiting for care that may or may not have partial privacy barriers. I also understand that if at any time I desire care in a private room, INNER LIGHT CHIROPRACTIC, P.A. will make that available to me.

HIPPA- Release of Information

By signing this form, I am granting consent to INNER LIGHT CHIROPRACTIC, P.A. to use and disclose my protected health information for the purposes of care, payment and health care operations. The Notice of Privacy Practices (requested) provides more detailed information about how protected health information may be used and disclosed.

Message Authorization

I authorize the doctors of INNER LIGHT CHIROPRACTIC, P.A. and/or the office staff to leave a message either on my phone/answering machine/voicemail or with the person who answers the telephone either at home or at the work number I provided. If you prefer email or text messages, this can be arranged as well. The information could include Personal Health Information, regarding care or account status and if we are unable to reach you, a phone call will be ultimately used:

_____ Text _____ Voicemail _____ Email

Phone Number:_____ Email Address:_____

EMERGENCY CONTACTS

1st Contact_____ 2nd Contact_____

Address_____ Address_____

_____ _____

Phone _____ Phone _____

I have read the INNER LIGHT CHIROPRACTIC Office Policies and will honor them:

I certify that the personal information given to INNER LIGHT CHIROPRACTIC, P.A. to carry out care and collections is true and correct to the best of my knowledge:

_____ _____

Practice Member's Printed Name Parent or Guardian Printed Name

_____ _____

Practice Member's or Parent/Guardian Signature Date

INNER LIGHT CHIROPRACTIC
"HEALTHIER PEOPLE, HEALTHIER PLANET!" P.A.

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CASE HISTORY

NAME_____DATE_____
ADDRESS_____CITY_____STATE_____ZIP_____
H. PHONE(____)_____ W. PHONE(____)_____ C. PHONE(____)_____
DATE OF BIRTH_____ (AGE_____) SOCIAL SECURITY #_____
OCCUPATION_____ EMPLOYER_____
MARITAL STATUS: S M D W SPOUSES NAME_____
SPOUSES OCCUPATION_____ NUMBER OF CHILDREN & AGES_____
HAVE YOU EVER RECEIVED CHIROPRACTIC CARE? ❒ YES ❒ NO REFERRED BY_____

ABOUT YOUR HEALTH

The human body is designed to be healthy. Throughout life, events occur which damage your health. This case history will uncover the layers of damage, especially to your nerve system, that resulted in poor health. Following your exam, your chiropractor will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

LOSS OF WELLNESS

Let's begin at birth when you first damaged your nerve system, lost your wellness and began your journey to ill health.

YES	NO		PATIENT COMMENT If answer is YES	CHIROPRACTOR'S Comments
		1.BIRTH PROCESS		
_____	_____	Did your mother experience any falls & injury's during pregnancy?	_____	_____
_____	_____	Was the delivery long?	_____	_____
_____	_____	Was the delivery difficult?	_____	_____
_____	_____	Forceps?	_____	_____
_____	_____	Cesarean?	_____	_____
_____	_____	Breach?	_____	_____
_____	_____	Home birth?	_____	_____
_____	_____	Hospital birth?	_____	_____
_____	_____	Mother given drugs during delivery?	_____	_____
_____	_____	Was labor induced?	_____	_____
		2. GROWTH AND DEVELOPMENT (BIRTH THROUGH TEENAGE YEARS)		
_____	_____	Were you taught how to care for your spine?	_____	_____
_____	_____	Did you fall out of bed?	_____	_____
_____	_____	Did you have childhood sickness?	_____	_____
_____	_____	Did you have accidents?	_____	_____
_____	_____	Did you have surgery?	_____	_____
_____	_____	Did you take medication/drugs?	_____	_____
_____	_____	Were you picked on by siblings?	_____	_____
_____	_____	Did you experience child abuse?	_____	_____
_____	_____	Did you experience severe spanking?	_____	_____
_____	_____	Did you have your ear/chin pulled?	_____	_____
_____	_____	Chair pulled out when sat down?	_____	_____
_____	_____	Did you fall down stairs?	_____	_____
_____	_____	Were you yanked by your arm?	_____	_____
_____	_____	Did you have other traumas?	_____	_____

YES NO 3. LOSS OF WHOLE BODY HEALTH

_____	_____	Did/ do you smoke?	_____	_____
_____	_____	Did/ do you drink any alcohol?	_____	_____
_____	_____	Diet (Do you eat healthy foods?)	_____	_____
_____	_____	Have you been in accidents?	_____	_____
_____	_____	Have you had surgery & organs removed/ replaced?	_____	_____
_____	_____	Did/ do you take drugs prescriptive or non-prescriptive?	_____	_____
_____	_____	Did/ do you have occupational stress?	_____	_____
_____	_____	Did/ do you have physical stress?	_____	_____
_____	_____	Did/ do you have mental stress?	_____	_____
_____	_____	Did/ do you have sports injuries?	_____	_____

PRIMARY REASON FOR CONSULTING OFFICE

Finally, the years of continuing damage showed up as acute or chronic symptoms.

Present complaint_____
Pain or problem started on_____
Pains are: _____SHARP _____DULL _____CONSTANT _____INTERMITTENT
Intensity: _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10
Frequency: _____Daily _____2-3 times weekly _____Sporatic
Is this condition worse at certain times of the day? ___Morning ___Afternoon ___Evening ___During sleep
Is this condition interfering with work?_____ sleep?_____ routine?_____ other?_____
Is this condition getting progressively worse?_____ Other doctors seen for this_____
Are you using any home remedies?_____

OTHER SYMPTOMS:

_____HEADACHES	_____PINS & NEEDLES IN LEGS	_____LOSS OF SMELL
_____NECK PAIN	_____NUMBNESS IN FINGERS	_____LOSS OF TASTE
_____SLEEPING PROBLEMS	_____NUMBNESS IN TOES	_____DIARRHEA
_____BACK PAIN	_____SHORTNESS OF BREATH	_____FEET COLD
_____NERVOUSNESS	_____FATIGUE	_____HANDS COLD
_____TENSION	_____DEPRESSION	_____STOMACH UPSET
_____IRRITABILITY	_____LIGHTS BOTHER EYES	_____CONSTIPATION
_____CHEST PAINS	_____LOSS OF MEMORY	_____COLD SWEATS
_____DIZZINESS	_____EARS RING	_____LOSS OF BALANCE
_____FACE FLUSHED	_____FEVER	_____BUZZING IN EARS
_____NECK STIFF	_____FAINTING	_____OTHER SYMPTOMS

Have you been under medical care recently or for this problem?_____
Have you been taking prescriptive or non-prescriptive drugs_____
Have you had surgery?_____Any side effects from drugs or surgery?_____
Is there a family history of:

	HEART DISEASE	ARTHRITIS	CANCER	DIABETES	OTHER
Fathers side	_____	_____	_____	_____	_____
Mothers side	_____	_____	_____	_____	_____

ABOUT YOUR CARE

Chiropractic provides three types of care. The first is **Initial Intensive Care** which corrects the most recent layer of Spinal and Neurological damage(VSC). This care usually reduces or eliminates the symptoms. Then begins **Reconstructive Care** which corrects the years of damage that occurred when there were few symptoms. And finally, Chiropractic offers a genuine approach to **Wellness Care**. All of these options will be explained at your report of findings. Then you'll be able to begin a course of care that fits your health goals.

Dr. Signature_____Date_____