Informed Consent

Medical doctors, chiropractic doctors, osteopaths, and physical therapists that perform manipulation are required by law to obtain your informed consent before starting treatment.

I, _____, Do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Although spinal and extremity manipulation/adjustment and soft tissue therapy are some of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows: soreness, bruising, dizziness, fainting, fractures, joint injury, stroke, or bleeding. Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other people of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me including, rest, home applications of therapy, prescription or over-the counter medications, exercises, and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening

pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthier.

I have read or have read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment,

Patient Signature:_____Date:_____

Office Policy

Permission to Communicate: I authorize and give permission to the doctors and/or staff to communicate with me by mail, e-mail, phone calls to home, work, and cell phone. I understand this communication will only be regarding appointments, clerical issues, and clinical issues. I understand that due diligence will be employed in being discreet about any clinical issues conveyed via above modes of communication. I understand I have the right to refuse certain types of communication by notifying Atlas Aligned LLC dba Comprehensive Chiropractic Center (CCC) staff or doctors in writing.

Medical Education Advancement: For the purposes of advancing the health care professions, I consent to the admittance of observers to the treatment room. Observers will only be those in a healthcare profession, or currently in school for a healthcare related field. I understand that if I am not comfortable with the observer, I can notify the doctor and the observer will be asked to leave.

Clinical Research: I understand that the doctors of CCC may use my case history and treatment outcomes for the purpose of clinical research. I authorize the doctors to use the appropriate information for research studies, which will only include information related to my condition and treatment and will not include any personal or identifying information.

HIPAA: I acknowledge that I have received and reviewed the HIPAA policies of this office.

I acknowledge that I have read and fully understand the above office policies.

Patient Signature:_____Date:_____

Financial Policy

Insurance Billing Policy: I acknowledge that the doctors at CCC are an in-network provider for select insurance plans. I realize there are copays and deductibles that are, as the patient my responsibility to pay. For those insurance plans which the doctor is out-of-network the patient may choose to pay via private pay options at the time

of service rendered. Patient may request a superbill and can submit it on their own behalf to their insurance provider for reimbursement. Reimbursement is dependent on the individual out-of-network private insurance and will be sent directly to the patient. Comprehensive Chiropractic Center will bill my insurance company that they are in-network with on my behalf, and I realize I will be responsible for all remaining fees my insurance company deems to be my responsibility.

Private Pay Policy: All patients acknowledge that they are financially responsible to remit payment in full for all services provided to them. Accepted payment methods are credit card, debit card, check, cash, HSA, and FSA. All patients further understand and agree that CCC will not submit any billing data or related claim(s) for, or on, their behalf to any out-of-network private insurance program, with whom they have insurance coverage, unless otherwise required by applicable law.

I acknowledge that I have read and understand the above financial policies:

Patient Signature:_____Date: _____