

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to a Doctor of Chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Chiropractic Physician of the Osmon Chiropractic Center. The Chiropractic Physician provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

♦ **The nature of the chiropractic adjustment.**

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel or sense movement.

♦ **The material risks inherent in chiropractic adjustment.**

As with any healthcare procedure, there are certain complications, which may arise during chiropractic manipulation. Those complications include: fractures, disc injuries, dislocations, muscle strain, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

♦ **The probability of those risks occurring.**

Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare."

♦ **The availability and nature of other treatment options.**

Other treatment options for your condition include:

- ♦ Self-administered, over-the-counter analgesics and rest
- ♦ Medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers.
- ♦ Hospitalization with traction
- ♦ Surgery

I understand that if I am accepted as a patient by a physician at Osmon Chiropractic Center, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Patient Name: _____

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

**Patient Acknowledgement and Receipt of
Notice of Privacy Practices Pursuant to HIPAA and Consent
for Use of Health Information**

Name _____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

By _____ Date _____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By _____ Date _____
Signature of Parent/Guardian (circle one)

Please list below anyone you would like to have access to your protected health information (PHI).

	<u>Name</u>	<u>Relation</u>	<u>Phone</u>
1.			
2.			
3.			
4.			
5.			

**ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR
PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE**

Re: Assignment of Insurance Benefits/Authorization for Payment

Patient: _____

Employer: _____

Claim/Group#: _____

Insurance ID# and Date of Birth: _____

I hereby instruct and direct the payment of all professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy to:

Dr. Lloyd Dane Ericson, DC
Osmon Chiropractic Center
1332 W. Arch Haven Ave. Ste. C
Bloomington, IN 47403

Tel: (812) 333-7447
Fax: (812) 333-7442
Email: info@drosmon.com

as payment for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

_____ c/o Dr. Lloyd Dane Ericson

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

Insured: _____ Date: _____

Witness: _____ Date: _____