STRONG
CHIROPRACTIC OFFICE S.C.
"Strong on Health"

☐ 1426 S. Commercial St. Neenah, WI 54956
Phone (920)725-0800 Fax (920)725-6308
☐ 1040 S. Koeller St. Oshkosh, WI 54902
Phone (920)426-9898 Fax (920)426-9810
☐ 1801 N. Richmond Appleton, WI 54911
Phone (920)831-4110 Fax (920)831-4111

Patient Health Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all the staff has been trained in the area of patient record privacy and privacy official has been designated to enforce those procedures in the office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient	Patient Signature	Date

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Informed Consent Waiver To Treat

PATIENT NAME: _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of chiropractic adjustment.

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may 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 "cracked" your knuckles. You may feel a sense of movement.

Analysis/ Examination/ Treatment

As part of the analysis, examination, and treatment, you are consenting to the following procedures:

___ Spinal Manipulative Therapy
___ Range of Motion Testing
___ Muscle Strength Testing
___ Ultrasound
___ Radiographic Studies
___ Other (please explain)

___ Palpation
___ Orthopedic Testing
___ Postural Analysis
___ Hot/Cold Therapy

___ Vital Signs
___ Basic Neurological Testing
___EMS

_____

_____

Patient should initial each procedure they are consenting to.

The material risk inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. 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 doctor will make every reasonable effort during the examination to screen for contraindications to care; however if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the doctor.

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. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your conditions may include:

- Self-administered, over-the –counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read (or have had read to me) the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Strong Chiropractic office doctor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

_____
Patient's Name

_____
Signature

_____
Signature of Parent or Guardian
(If a minor)

Dated: _____

Doctor's Name: _____

Signature _____

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PAYMENT CONTRACT AND PATIENT CONSENT FORM

Thank you for choosing Strong Chiropractic for your health care. We appreciate the opportunity to serve you and are committed to providing you with the best possible care. As part of our service to you, we try to contain the ever-rising cost of healthcare. In an effort to do this, we have implemented the following Financial Policy. Your cooperation in following our financial policy will allow for prompt settlement of your claim. As a courtesy to you, we will file all medical claims, with the primary and secondary insurance. However, you must provide us with current copies of your insurance and notify us immediately when there are changes in this information. Please read this Financial Policy and sign below

- **CO-PAYMENT:** If your insurance requires a co-payment they are due at the time of service. We accept Visa and MasterCard. Check or cash (exact change appreciated)
- Payment is due and payable in it's entirety for co-payments, deductibles; co-insurances and etc. at the time service is rendered. Unless prior arrangements have been made with our billing office, accounts must be satisfied within **90 day** or it may be referred to a collection agency unless the account is on a regular scheduled payment plan. If you have a financial hardship; documentation is required in order to make arrangements. We may reschedule appointments should bills go unpaid and no attempt has been made to reconcile the account.
- Appropriate adjustment to your account will be made should we hold a contract with your insurance company.
- There is a **$40.00** service charge for any returned check, missed appointment, no show or cancellation with less than 24 hours.
- Any questions regarding your insurance coverage, eligibility and benefits (payment) must be communicated by you directly with that company, as you hold the contract with that company, we do not. Check your policy for Chiropractic coverage.
- **LATE PAYMENT CHARGES:** a late payment charge of 1 ½% per month will be added to all outstanding balances over 90 days.

I have read and agree to the terms of this policy and have received/waived a copy of the Payment Contract and Patient Consent Form. I hereby authorize Strong Chiropractic Office S.C. to submit and collect their service fees from my Health insurance, Workers Compensation, Employer or Attorney as indicated. I further authorize Strong Chiropractic Offices to furnish my Insurance Carrier, Employer or Attorney with a full report of medical information necessary to pay the claim. I authorize my Insurance Carrier or Attorney to pay directly to Strong Chiropractic Offices all sums due for chiropractic services or to withhold such sums from settlement, claim judgment, or verdict as may be necessary to protect Strong Chiropractic Offices for their fees.
I also direct my Attorney to issue a **"Letter of Protection"** which states all amount are protected from settlement proceeds. I understand and agree that if I do not recover sufficient monies in my case; I am still personally responsible for payment and I am responsible for any attorney's fees, collection agency costs, court costs or any other expense incurred in order to collect the amount owned to Strong Chiropractic Offices S.C. I agree that a photocopy of this original authorization shall be considered equally authentic as the original.

X_____ **X**_____
Signature of responsible Party **Relationship** to patient

X_____ _____
Print Name of Responsible Party Date