



Payment Policy: *Who Pays for Your Care?*

Dear Patient:

We know auto accidents are stressful and painful. The doctors in our office have 35+ years of successfully treating auto injuries. Dealing with auto insurance companies is confusing and frustrating. We hope this answers questions regarding payment of services received that you might have.

Who pays for my care if the accident is my fault?

Under Colorado law, medical payment coverage (med pay), under your auto insurance policy, is the **primary billing party and will be billed first**. If you have waived your rights to medical payment coverage on your auto insurance policy or choose to forgo medical payment coverage usage, you are now considered the primary source of payment and you **must provide payment at the time services are rendered**. If **medical payment coverage is exhausted you are now responsible for payment**. Most, not all **health insurance companies will deny coverage** for auto-accidents much like they will not pay for an accident that occurs at work.

Who pays for my care if the accident is **not** my fault?

Under Colorado law, the presumed, at-fault driver's insurance company is **never obligated to pay for medical treatment for you at any time**, much less as and when it is obtained, or for any other expenses until and unless it chooses to or its insured has been legally determined to be at fault. Even then, its **duty is only to its insured, never you**. The treatment bills will be taken into consideration if a settlement is being negotiated but, again, the other drivers insurance company never has to pay for the care you have received. So, when making decisions about whether to continue care, please make sure to **consider your own sources of payment**. If you have **medical payment coverage (med pay)** under your auto policy, that insurance is primary and will be billed first. It is **illegal in the state of Colorado to raise auto policy rates based on medical payment coverage usage**. If you are **legally deemed not at-fault** a third party lien for secondary payment will be considered for continuation of care, only after your medical payment coverage is exhausted, and **payment must be rendered upon settlement**. However, should payment not be received within 6 months after termination of care, or should you terminate care before being dismissed by the physician, **you will be charged the amount outstanding on your account to a designated credit card**.

By signing this you are stating that you have fully read and understood Bellevue Spine and Wellness's payment policy and agree to abide by the aforementioned policy.

Printed Name

Signature

Date

CONFIDENTIAL AUTO ACCIDENT INFORMATION

(Please print clearly)

Last name First name MI Sex: ()M ()F Date

Address City State Zip Code

Home phone Work phone Cell phone

Social Security Date of Birth Email Address

Emergency Contact Relation Home phone Work phone

Date of Auto Accident: _____ Time _____ AM/PM

List all those in the vehicle with you:

Name	Relationship	Age	Injured
1. _____			Yes() No()
2. _____			Yes() No()
3. _____			Yes() No()
4. _____			Yes() No()

Location of the accident: _____

What were the road and weather conditions like? _____

Total number of vehicles involved in accident: ()1 ()2 ()3

The impact to your vehicle occurred from the: ()Front ()Rear ()Left Side ()Right Side

()Other _____

Total number of impacts to your vehicle: ()1 ()2 ()3 ()4 ()Other _____

Estimated speed of your vehicle at the time of impact: _____ mph () Stopped

Estimated speed of other vehicle at the time of impact: _____ mph () Stopped

Did you anticipate the impact? ()Yes ()No

What was the position of your head just before the impact? _____

Were you wearing a: () Lap belt () Lap and shoulder belt () Neither

Was there a headrest? () Yes () No Did any windows break in your vehicle? () Yes () No

If yes describe: _____

Make and model of your vehicle: _____ Year _____

Who was called or came to the scene? () Highway Patrol () Local Police
() Sheriff () Paramedics
() Ambulance () Other _____

Was a report made? () Yes () No Do you have a copy of the report? () Yes () No

Were you on company business at the time of the accident? () Yes () No

If yes, did you report the accident to your employer? () Yes () No

Did you receive any first aid at the scene of the accident? () Yes () No

If yes, what was done and by whom?

Did you go to the emergency room? () Yes () No

Did you go to a Doctor's office? () Yes () No

If you answered "yes" to either of the 2 questions above, complete the following:

A. Who attended you there? _____

B. What was done for you there? () Examination () Medication () Muscle Relaxants
() Anti-inflammatory () X-Rays () Supports/Braces () Pain Medication () Other _____

C. What diagnosis were you given? _____

D. Were you told to do anything by the attending Doctor? () Yes () No

If yes, please explain: _____

Were you hospitalized as a result of the injuries you sustained from the accident? () Yes () No

If yes, complete the following information:

Name of Hospital/Location: Entered/Discharged Treating Doctor

What was done for you at the hospital? _____

Describe how you felt:

A. Immediately after the accident: _____

B. Later that day: _____

C. The next day: _____

Did you see any other health care professional since the day of the auto accident? () Yes () No

If yes, please complete the information below. Begin with the person you saw first and proceed to the most recent.

Name	Title	Dates Seen	What was performed?

What medications, prescribed or not, are you currently taking to treat symptoms of your injury?

What other medications, prescribed or not, are you currently taking for problems unrelated to your injury?

Have you missed work *as a result of* the auto accident? () Yes () No

If yes, please provide details:

Health History

Have you had any significant injury or illness of any type “prior” to the injury? () Yes () No

If yes, what was the nature of the problem and when did it occur? If professional care was rendered, how long were you treated, by whom and what was performed?

Have you ever had any surgeries? () Yes () No

If yes, what for and by whom and what was done:

Check all that apply:

Present	Past		Present	Past		Present	Past	
		Headaches			High Blood Pressure			Diabetes
		Neck Pain			Heart Attack			Excessive Thirst
		Upper Back Pain			Chest Pains			Frequent Urination
		Mid Back Pain			Stroke			Smoking/Tobacco Use
		Low Back Pain			Angina			Drug/Alcohol Dependence
		Shoulder Pain			Kidney Stones			Allergies
		Elbow/Upper Arm Pain			Kidney Disorder			Depression
		Wrist Pain			Bladder Infection			Systemic Lupus
		Hand Pain			Painful Urination			Epilepsy
		Hip Pain			Loss of Bladder Control			Skin Disorder
		Upper Leg Pain			Prostate Problems			HIV/AIDS
		Knee Pain			Abnormal Weight Gain/Loss			Ankle/Foot Pain
		Appetite Loss			Jaw Pain			Abdominal Pain
		Joint Pain/Stiffness			Ulcer			Arthritis
		Hepatitis			Rheumatoid Arthritis			Liver/Gallbladder Disorder
		Cancer			General Fatigue	<i>Women Only</i>		
		Tumor			Muscular Disorder			Birth Control Pills
		Asthma			Visual Disturbances			Hormonal Replacement
		Chronic Sinusitis			Dizziness			Pregnancy
		<i>Other:</i>						

Please list any known **allergies:**

Is there anything else you feel we should know?

CURRENT MEDICAL COMPLAINTS

Please use the space provided below to describe any medical complaints you are currently experiencing, or any additional comments you may wish to make regarding your condition.

Mark the areas on the body where you feel the described sensations. Use the appropriate symbol. Include all affected areas.

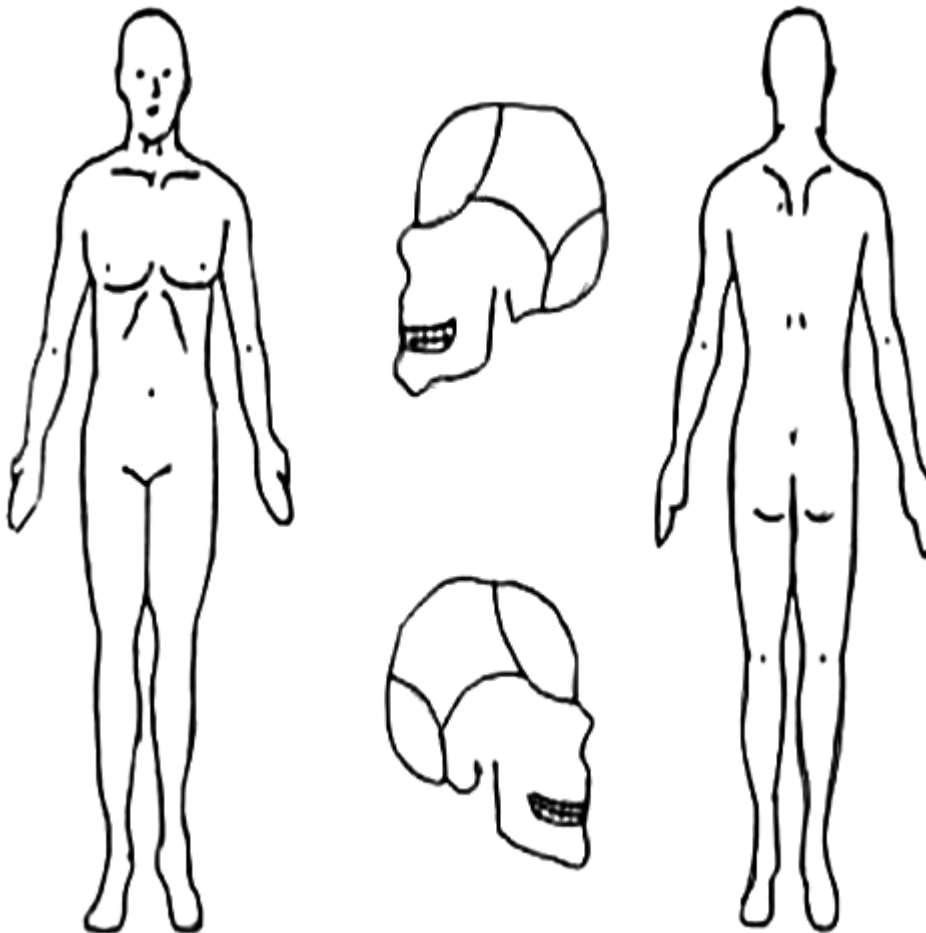
Numbness = =

Pins and Needles oo

Burning xx

Stabbing/Sharp Pain //

Aching/Dull Pain ((



INSTRUCTIONS: Please print your response and circle the most appropriate choice(s):

Primary complaint?

Secondary complaint?

Tertiary complaint?

When did the problem begin?

This problem began:

Gradually
Suddenly

Gradually
Suddenly

Gradually
Suddenly

This problem can best be described as:

Dull
Throbbing
Sharp
Stabbing
Burning
Tingling
Other: _____

Dull
Throbbing
Sharp
Stabbing
Burning
Tingling
Other: _____

Dull
Throbbing
Sharp
Stabbing
Burning
Tingling
Other: _____

This problem is:

Constant
Near Constant
Frequent
Rarely Present
Other: _____

Constant
Near Constant
Frequent
Rarely Present
Other: _____

Constant
Near Constant
Frequent
Rarely Present
Other: _____

This problem is worse with:

Coughing
Sneezing
Straining
Sleeping
Lifting
Rest
Activity
Weather Changes

Coughing
Sneezing
Straining
Sleeping
Lifting
Rest
Activity
Weather Changes

Coughing
Sneezing
Straining
Sleeping
Lifting
Rest
Activity
Weather Changes

Other: _____

Other: _____

Other: _____

This problem is better with:

Medication
Rest
Activity
Stretching
Treatment
Other: _____

Medication
Rest
Activity
Stretching
Treatment
Other: _____

Medication
Rest
Activity
Stretching
Treatment
Other: _____

What household, social, recreational, at work activities are now difficult or impossible to do because of your condition?

QUESTIONNAIRE FOR POST-CONCUSSION SYNDROME

Please place a check mark “” in the space provided next to any of the follow symptoms that you have noticed since your accident. If you are unsure, then please place a “?” in the space. If you should have any additional symptoms of an unusual nature, then please list them in the space provided at the bottom of the page. Thank you for your assistance.

- ____ 1. Light headedness
- ____ 2. Vertigo/dizziness
- ____ 3. Neck pain an/or stiffness
- ____ 4. Headache
- ____ 5. Photophobia (eye sensitive to bright light)
- ____ 6. Phonophobia (sensitivity to loud noises)
- ____ 7. Tinnitus (ringing in the ears)
- ____ 8. Impaired Memory
- ____ 9. Difficulty Concentrating
- ____ 10. Impaired comprehension or awareness
- ____ 11. Forgetfulness
- ____ 12. Impaired logical thinking
- ____ 13. Difficulty with new or abstract concepts
- ____ 14. Insomnia (difficulty sleeping)
- ____ 15. Easy Fatigability
- ____ 16. Apathy
- ____ 17. Outbursts of anger
- ____ 18. Mood swings
- ____ 19. Depression
- ____ 20. Loss of libido
- ____ 21. Personality change
- ____ 22. Intolerance to alcohol

Comments: _____

Insurance Billing Information

Regardless of fault, in the State of Colorado, your MedPay (part of your auto insurance policy) will cover medical expenses. If you do not have MedPay and the accident was your fault, you are responsible for all treatment charges. If you do not have MedPay and the accident was not your fault, the party (3rd party) at fault will be responsible and all medical expenses will be paid at the conclusion of treatment.

Do you have MedPay? ____ Yes ____ No **Amount of Coverage:** _____

Your Auto Insurance Company: _____

Adjuster Name: _____

Adjuster Phone #: _____

Claim #: _____

If you auto insurance does not include MedPay:

3rd Party Insurance Company: _____

Adjuster Name: _____

Adjuster Phone #: _____

Claim #: _____

If you have an attorney:

Attorney Company Name: _____

Attorney Name: _____

Attorney Phone #: _____

**CREDIT GUARANTEE
ACCIDENT INSURANCE ASSIGNMENT
PERSONAL BALANCES**

INSURANCE ASSIGNMENT:

Our Accident Insurance Liability Program is designed to render you immediate care and keep your out-of-pocket expenses to a minimum. As a courtesy to you, we will bill your insurance carrier on your behalf and wait up to 6 months for payment. As a prerequisite, we ask that you provide a credit card to guarantee payment of your bill and that you provide us with the your complete accident insurance information.

FILING PROCEDURE:

We will submit claims on your behalf to your insurance carrier.

Balances not paid within 6 months after conclusion of your care will be charged to your designated credit card below. You will be sent a payment voucher. Should settlement be reached prior to the 6 month grace period or should care be terminated for any reason prior to your physician dismissal all balances become due immediately, will be charged to your credit card and are subject to monthly interest charges.

CREDIT CARD: ___ Visa ___ Master Card ___ Discover ___ AMEX

Cardholder Name (as it appears on card): _____

Card No. _____ Exp. _____

I agree to the above terms and authorize you to bill the charge card. I understand that should payment not be received within 6 months after termination of my care or should I terminate care before being dismissed by my physician. I will be charged the amount outstanding on my account.

Patient Name: _____ Date: _____
(Please Print)

Signature: _____



Irrevocable Lien, Assignment of Benefits, and Security Interest

Patient/Guardian: _____ (hereafter "patient")

Date of Injury: _____

Provider: **Bellevue Spine and Wellness**

Patient, in order to receive care, treatment, products, and services (collectively referred to hereafter as "Services") from Provider or Provider's Assignee (hereafter collectively referred to as Provider), hereby executes this Irrevocable Lien, Assignment of Benefits, and Security Interest (hereafter "Document") in favor of Provider, and any Assignee designated at Provider's discretion. Patient agrees as follows:

1. Provider, shall have an irrevocable lien against, and a security interest in, any settlement, award, judgment, verdict, or recovery arising out of the injury sustained by patient on the above-referenced Date of Injury. Patient assigns, to Provider, the proceeds from any such settlement, award, judgment, verdict, or recovery in an amount equivalent to Patient's outstanding balance for Services with Provider.
2. Patient assigns to Provider, in an amount equivalent to Services provided, any benefits available, or to which Patient may be entitled, and any legal or contractual rights patient may have under health insurance, uninsured/underinsured motorist coverage, and medical payment coverage. On Patient's behalf, Patient authorizes Provider to receive a complete copy of Patient's, or any third-party's insurance policy, including declarations sheets, endorsements, conditions, limitations, benefits, exclusions, and policy limits.
3. Patient understands and agrees that this Document is valid, secured, and enforceable upon execution and shall remain valid even if Provider's rights hereunder are assigned. Patient consents to any assignment at the discretion of Provider. Patient agrees that Provider may file this, and any other Document, with the appropriate court, any insurance carrier, with Patient's attorney, or the Colorado Secretary of State, as Provider so desires. Patient further authorizes Provider to provide copies of Patient's medical records to Patient's attorney and any insurance carrier who may be responsible for payment of Services, either through contract or due to a third-party's liability. Patient acknowledges receipt of Disclosures/Advisements pursuant to C.R.S. 38-27.5-104, *et. seq.*
4. Patient directs any attorney representing Patient to acknowledge and honor this Document, even if not signed by the attorney, and to make payment to Provider pursuant to the same. This document is intended to be valid and enforceable, even if not signed by Patient's attorney. Patient's attorney is advised, that by execution of this Document, that Patient recognizes that Provider is a third party with an undisputed interest in Patient's claim/case as anticipated by Colorado Formal Ethics Opinion 94.
5. Patient authorizes and directs Patient's attorney, Patient's insurance company, or any third-party insurance company to disclose all insurance benefits, offers, status of negotiations, and any final settlement or judgment amount, along with date of settlement, all provider or insurer lien reductions, and disbursement amounts to others (actual or proposed).

6. Provider shall not be responsible, either in part or in whole, for payment of attorney's fees, expenses, or costs which Patient may incur for the collection of funds due from third parties or insurance benefits. Patient understands that Provider is not subject to either the "made-whole rule" or the "common fund doctrine."

7. This agreement does not create a continuing obligation to provide Services for Patient. Should Patient or Patient's representative request that Provider bill services to health or other insurance, such request shall be made in writing. In the event Provider is asked to bill health or other insurance, Patient shall be responsible for payment of all co-payments or deductibles at the time of service, unless another method of payment is agreed to between Patient and Provider, in writing.

8. This Document applies to amounts currently owed by Patient to Provider and to amounts which may be incurred in the future. Patient agrees that this Document shall apply to any balances owed by patient for past or future treatment, whether or not such Services are related to the Date of Injury as set forth above.

9. Patient agrees that this document shall be governed by the laws of Colorado and any dispute under this document, or for Services provided, shall be brought in the county where Patient received Services.

10. In the event patient has made any misrepresentations or committed fraud, Patient shall be responsible for Provider's reasonable attorney's fees and costs should collection efforts be undertaken by Provider, whether or not a lawsuit is undertaken.

11. If any provision of this agreement is deemed to be unenforceable for any reason, the remaining portions shall still be enforceable and have binding effect.

Dated this ____ day of _____, 20____.

Signature of Patient/Guardian

Printed Name

Address

City, State, Zip

ACKNOWLEDGEMENT

I, the undersigned attorney, am the attorney of record for Patient named above. I hereby acknowledge receipt of the foregoing Irrevocable Lien, Assignment of Benefits, and Security Interest and hereby agreed to honor and observe the terms herein. **I provide this acknowledgement with the understanding that attorneys' fees and costs shall be deducted BEFORE payment of any Services pursuant to this Lien.**

Attorney Signature

Attorney Printed Name

Firm Name

determine the health-care provider's or its assignee's share of the injured person's net judgment, settlement, or payment;

III. The health-care provider or its assignee may not assign a health-care provider lien to a collection agency or debt collector.

(d) That a health-care provider's assignee's compensation from the injured person is based on the difference between the health-care provider's usual and customary billed charge and the amount that the assignee pays to purchase the health-care provider lien;

(e) Of any common ownership interest between the holder of the health-care provider lien and the injured person's legal counsel. No such relationship exists;

(f) Of any common ownership interest between the assignee of a health-care provider lien and any health-care provider who is providing treatment or who may provide treatment to the injured person under the terms of the health-care provider lien; and

(g) That if the injured person has obtained health insurance even after a health-care provider lien has been created, and the injured person or the injured person's legal counsel so informs the holder of the health-care provider lien, all future care may be billed to the health insurance carrier at the injured person's discretion.

(2) Nothing in C.R.S. 38-27.5-101, *et. seq.* changes any obligation of the health-care provider or its agents under the "Colorado Medical Assistant Act", Articles 4 to 6 of Title 25.5

(3) Upon request by the injured person or the injured person's legal counsel, the holder of a health-care provider lien shall provide in writing to the injured person an itemized statement of all the billed charges for treatment comprising the total value of the health-care provider lien as the billed charges are accrued, to the extent practicable, and when the health-care provider lien is final. The final itemized statement must include a summary of all treatments provided, the total amounts billed for each treatment, and the total amount of the health-care provider lien due and owing.

I acknowledge receipt of the foregoing disclosures and advisements as required by Colorado law.

Dated this ____ day of _____, 20 ____.

Signature of Patient/Guardian

Printed Name



REQUIRED DISCLOSURES PURSUANT TO C.R.S. §38-27.5-104

Patient/Guardian: _____

Health-care provider: **Bellevue Spine and Wellness**

Date of Injury: _____

Pursuant to Colorado law, Patient/injured person is provided with the following disclosures and advisements:

- (1) Before a health-care provider lien is created, a health-care provider or its assignee must make the following disclosures and advisements to the injured person:
 - (a) The following are potential methods for payment of a health-care provider's billed charges:
 - I. The creation of a health-care provider lien;
 - II. The use of benefits available from any payer of benefits as defined in section 38-27-101(9) to which the injured person is a beneficiary, including that the injured party can obtain information about the payer of benefits' network from the payer of benefits or the health-care provider;
 - III. Any other payment method or arrangement agreed to in writing by both the health-care provider or its assignee and the injured person; or
 - IV. A combination of the payment methods specified in subsections (1)(a)(I) to (1)(a)(III) of C.R.S. 28-27.5-104, as set forth above.
 - (b) That the health-care provider or its assignee is not a health insurer or payer of benefits;
 - (c) That, except in the event of fraud or misrepresentation by the injured person:
 - I. If the injured person does not receive a judgment, settlement, or payment on the injured person's claim against third parties or under an uninsured or underinsured motorist policy, the injured person is not liable to the holder of the health-care provider lien for any portion of the health-care provider lien;
 - II. If the injured person receives a net judgment, settlement, or payment that is less than the full amount of the health-care provider lien, the injured person is not liable to the holder of the health-care provider lien for any amount beyond the net judgment, settlement, or payment, and the holder of the health-care provider lien may not file a complaint or counterclaim against the injured person directly to be reimbursed for any amount beyond the net judgment, settlement, or payment. Nothing in this section prevents a health-care provider or its assignee from initiating a declaratory judgment action or participating in an interpleader action or claim pursuant to the Colorado Rules of Civil Procedure, or any other similar action or claim, to



**ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN
APPOINTMENT AND/OR DESIGNATION AS AN ERISA/PPACA REPRESENTATIVE AND A
BENEFICIARY**

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Bellevue Spine and Wellness, as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as BSW) the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided.

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to BSW for any and all medical/healthcare services, supplies, tests, and/or medications that *have been* or *will be* rendered or provided; as well as designating and appointing BSW as my beneficiary under all health insurance or medical plans which I may have benefits under.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby assign directly to BSW all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA plan, PPACA plan, or insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our representative, ERISA representative, or PPACA representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to either BSW, myself, and/or my family members as a result of services rendered by BSW, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan or insurer. I hereby also declare that BSW is my/our beneficiary regarding my/our health plan as contemplated by ERISA and PPACA, and that BSW can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment and/or designation will remain in effect unless revoked in writing. A photocopy or scan of this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____ 20____.

Patient Signature

Patient Name Printed

Signature of Legal Guardian/Representative (if applicable)

Informed Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

Sign here: X _____ I have read and understand the above consent form.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____ I wish to receive a paper copy of Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office. If I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

This serves a notice that as part of our efforts to deliver the most consistent healthcare we can to every patient, we use an electronic healthcare system that enables us to retrieve up to 13 months of prescription history through your insurance carrier.

I acknowledge that it is the policy of this office to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness (Office Staff): _____ Signature: _____ Date: _____

Informed Consent to Chiropractic Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injection, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about this consent, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office. I understand that I will receive appointment reminders via text message.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness (Office Staff): _____ Signature: _____ Date: _____