Clark Road Chiropractic Center

3220 Clark R. Sarasota, FL 32431 P: 941-923-4357 F: 941-923-9943

INFORMED CONSENT TO TREATMENT

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 the chiropractic care.
The Doctors of Chiropractic in this office are trained to provide chiropractic adjustments, physiotherapy modalities and received additional training to provide acupuncture therapy. There are several ways these modalities may be applied. Chiropractic care is an alternative and conservative form of healthcare. Although the risks are small, it is our obligation to inform you of them. The doctors 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 my attention it is your responsibility to inform the doctor prior to treatment rendered. Massage Therapy is also provided in this clinic via a license massage therapist. It is your responsibility to provide her with accurate and up to date health history or if you have any contraindications so massage such as blood conditions or contagious skin conditions.

The availability and nature of other treatment options.
Other treatment options for your condition may include:
• Self-administered, over-the-counter analgesics and rest.
• Medical care and prescription drugs such as anti-inflammatory, muscle relaxants, painkillers, and injections
• 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.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. In addition, acupuncture treatment involves risks such as forgotten needles, bruising, lung puncture or slight bleeding. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. I understand that the doctor is not providing (allopathic) medical care, and that I should look to my primary care practitioner (i.e., MD) for those services and for routine check-ups. Massage therapy also has associated risks which include but are not limited to bruising, muscle spasms, and fractures.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy, acupuncture, massage and/or diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the licensed Doctor of Chiropractic who now or in the future work at the clinic or office listed above.

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. 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. I hereby give my consent to that treatment.

PATIENT'S NAME (print): _____ Date of Birth: _____/_____/_____

Name of person authorizing treatment of MINOR or DEPENDANT (print): _____

PATIENT/GUARDIAN'S SIGNATURE: _____ DATE: ____/_____/_____

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REQUIRED: CONFIDENTIAL PATIENT HEALTH RECORD

(Please print)

NAME: _____
Date of Birth: _____/_____/_____
ADDRESS: _____
_____
EMERGENCY CONTACT: _____
PHONE: ( ) _____

PRIMARY PHONE: ( )_____ M H W
EMAIL: _____
**Your email will be enrolled into our patient portal. Check* ☐ to opt out

EMPLOYER: _____
OCCUPATION: _____

HOW DID YOU HEAR ABOUT US? ☐ Referred by _____ ☐ Google ☐ Facebook
☐ Yelp ☐ Insurance Website ☐ Walk-In ☐ Met the doctors at an event ☐ I am a previous patient

IS THIS VISIT DUE TO AN ACCIDENT? -Yes- -No- DATE OF INJURY: _____/_____/_____
ATTORNEY'S NAME: _____ PHONE: ( ) _____

Patient History: Gender: ☐ M | ☐ F Height: _____ Weight: _____*lbs.*
Smoking Status: ☐ Current | ☐ Occasional | ☐ Past | ☐ Never
Do you drink Alcohol? ☐ YES | ☐ NO Do you drink Coffee? ☐ YES | ☐ NO

SIGNIFICANT HEALTH HISTORY: _____
SURGERIES: _____
CURRENT MEDICATIONS: _____
Allergic to any medications? _____
PRIMARY PHYSICIAN: _____ PHONE NUMBER: ( )_____
Other doctors you see (OB, Neurologist, orthopedist, etc.): _____
TREATMENT YOU ARE SEEKING: (check all that apply) ☐ CHIROPRACTIC ☐ ACUPUNCTURE ☐ MASSAGE
☐ STRETCHING ☐ A.R.T. ☐ ORTHOTICS ☐ PAIN MANAGEMENT ☐ REHABILITION ☐ NUTRITIONAL COUNSELING

GOALS: People go to chiropractors for a variety of reasons and there are different levels of care.
Please check the type of care desired so that we may provide you the most appropriate management:

STAGE 1 ____ Pain relief: just get rid of the pain. Relief is short term.
STAGE 2 ____ Rehabilitation: get rid of the pain, but then fix the problem so it won't come back.
STAGE 3 ____ Optimal health: get rid of the pain, fix the problem, and then put me on a preventive maintenance plan so that I stay as healthy as possible.

"Thank you for your help in understanding as we try to maintain a complete and accurate record of your medical information. You are welcome to a copy of this data at any time. If you have any questions regarding this information, please let us know. "

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SYMPTOM INTENSITY AND FREQUENCY

CURRENT PAIN INTENSITY LEVELS

Describe on a scale of **1 - 10** how intense your pain or symptoms are. This includes the amount of aching, soreness, hurting, pain, numbness, and/or tingling levels currently present. A **zero (0)** indicates no symptoms exists. **1-3 pain** level is a minimum level and indicates that your pain is an annoyance only. A **4 pain** is a slightly moderate level, where pain doing activity begins to cause some disability. A **5-7 pain** is moderate in severity and has to restrict or limit your activity to a significant degree. An **8 - 10 pain** level is severe and indicates that your pain intensity is to a point where you have complete inability to perform some tasks. Please also indicate when the symptom first began in the ONSET column.

Circle the box that best describes your symptoms today

Pain Intensity	None	**MILD** Discomfort/Ache/Stiff			**MODERATE** Hurts/Sore/Bearable Sensation				**SEVERE** Sharp/Instense Pain			**ONSET:** Date that symptoms first began
Headahce	0	1	2	3	4	5	6	7	8	9	10	_____
Neck region	0	1	2	3	4	5	6	7	8	9	10	_____
Arm/ Hand symptoms	0	1	2	3	4	5	6	7	8	9	10	_____
Mid Back region	0	1	2	3	4	5	6	7	8	9	10	_____
Low Back region	0	1	2	3	4	5	6	7	8	9	10	_____
Leg/Foot symptoms	0	1	2	3	4	5	6	7	8	9	10	_____
Other_____	0	1	2	3	4	5	6	7	8	9	10	_____

CURRENT PAIN FREQUENCY LEVELS

Describe how frequent you have symptoms such as pain, numbness, and tingling in the respected areas. A **zero (0)** indicates that no symptoms exist. **10-20% frequency** level is a minimum level and indicates that your symptoms are occasional. A **30-40% frequency** is a moderate level, meaning that symptoms are intermittent, coming and going. A **50-70% frequency** is an indication that the symptoms are present more often than not but still not constant. An **80-100% frequency** level is severe and indicates that your symptoms are constant.

Circle the box that best describes your symptoms today

Pain Frequency	None	Occasional		Intermittent		Frequent			Constant		
Neck region	0	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Arm/ Hand symptoms	0	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Mid Back region	0	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Low Back region	0	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Leg/Foot symptoms	0	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Other_____	0	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

CURRENT HEADACHE FREQUENCY & DURATION

A. How frequently do you have headaches/migraine currently?

- ☐ No headaches
- ☐ once a month
- ☐ twice a month
- ☐ once a week
- ☐ twice a week
- ☐ 3 times a week
- ☐ 4 times a week
- ☐ 5 times a week
- ☐ almost daily

B. How long does your typical headache/migraine last? _____ Hours _____ Days

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REVIEW OF SYSTEMS - "Check the box if you have or have had trouble with any of the following. Leave blank if not applicable".

GENERAL	**Past**	**Present**	**HEENT**	**Past**	**Present**	**SKIN**	**Past**	**Present**
Pain while sleeping			Headaches			Rashes/Itch		
Weight Loss			Migraines			Flushing		
Lethargy/Weakness			Vision Problem			Excess Acne		
Weight Gain			Nose Bleeds			Eczema		
Recurring Fever			Sore Throat			Psoriasis		
Chills			Hoarseness			Skin Cancer		
CARDIOVASCULAR	**Past**	**Present**	Swollen Glands			Nail Changes		
Pacemaker			Sinus Trouble			**GASTROINSTEINAL**	**Past**	**Present**
Heart Attack			Diff Hearing			Loss of Appetite		
Shortness of Breath			Dental Problem			Nausea/Vomiting		
Chest Pain/Pressure			TMJ Problems			Diarrhea		
Swelling of the Feet			**RESPIRATORY**	**Past**	**Present**	Constipation		
Blood Clots			Chronic Cough			Abdominal pain		
Deep Vein Thrombosis			Asthma			Ulcers		
Aneurysm			Short of Breath			Bloating/Cramping		
High Cholesterol			Exercise Intolerance			Heartburn/Reflux		
Hypertension			Sleep Apnea			Hemorrhoids		
High Blood Pressure			Emphysema			Hepatitis		
Palpitations			Pneumonia			Cirrhosis		
Atrial Fibrillation			**MUSCULOSKELETAL**	**Past**	**Present**	Diverticulitis		
Heart Murmur			Arthritis			Incontinence		
NEUROLOGIC	**Past**	**Present**	Rheumatoid Arthritis			**BLOOD/LYMPH**	**Past**	**Present**
Stroke			Joint Pain/Swell			Anemia		
Concussions			Neck Pain			Bleeding		
Frequent Headaches			Lower Back Pain			Bruising		
Migraines			Osteoporosis			Blood Clots		
Dizziness			Scoliosis			Cancer		
Fainting			Muscle Cramping			Leukemia		
Light Headedness			**ENDOCRINE**	**Past**	**Present**	Lymphoma		
Poor Balance			Diabetes			STDs		
Face Numbness			Thyroid Problems			HIV/AIDS		
Body Numbness			Sweating			Sickle Cell		
Muscle Weakness			Hot/Cold Intolerance			**URINARY**	**Past**	**Present**
Seizures			Weight Loss			Painful Urination		
Tremors			Weight Gain			Excess Urination		
Memory Loss			Excess Urination			Incontinence		
PSYCHIATRIC	**Past**	**Present**	Excess Thirst			Urgency		
Insomnia			Appetite Changes			Kidney Stones		
Diff Concentrating			**FEMALE**	**Past**	**Present**	**MALE**	**Past**	**Present**
Memory Loss			Menstrual Irregularity			Testicular Pain		
Depression			Hot Flashes			Prostate Disease		
Anxiety			Breast Lumps			**ALLERGIES**	**Past**	**Present**
Agitation/Irritable			Menopause			Seasonal		

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SIGNATURE ON FILE

- I understand that the following statements refer to the office of Clark Road Chiropractic Center
- I understand that I am ultimately responsible for my bill
- I authorize use of this form on all my related insurance submissions
- I assign my rights for any payments or benefits from any health insurance or medical benefits plan
- I authorize release of any health status information to all my insurance companies
- I authorize this office to act as my agent in helping me obtain payment from my insurance companies
- I authorize direct payment to this office
- I authorize this office to pursue appeals on denied or partially paid claims form my insurance companies
- I authorize this office to utilize any legal counsel to pursue any denied or partially paid claims from any of my insurance companies when necessary
- I permit a copy of this authorization to be used in place of the original

HMO/PPO LIMITATION IF LIABILITY

Your insurance plan may have limitation for services covered in our office. According to your specific plan, the following services may not be covered:

*Examinations *Re-evaluations *Hot/Cold Packs *Ultrasound *Massage Therapy
*X-rays *Advanced diagnostic imaging *Acupuncture *Rehabilitation Therapy
*Electric Muscle stimulation *Vitamins/ Supplements *Orthotics/ DME
*Chiropractic adjustment when related to "maintenance care"

Should any of these determinations be made by your plan, you agree that you have been informed before the services were rendered and you agree to be responsible for payment of the specific services listed above

Insurance Benefit Disclaimer: "A quote of benefits and/or authorization does not guarantee payment. Final determination will be made once claims are processed by your insurance company. Payment of benefits are subject to all terms, conditions, limitations and exclusions of the member's contract at the time of service

FINANCIAL POLICY

In order to receive the best care possible within your benefits, it is important that you comply with our financial policy:

1. Payment is expected at the time of service in the form of a deductible, co-payment, or co-insurance payment. * IT IS ILLEGAL TO DISCOUNT THESE FEES*
2. Your insurance policy is a contract between you and the insurance company, and you are responsible for any unpaid or denied claim, and for any collection fees, court costs, and attorney's fees if your account is turned over for collection.
3. If your insurance company sends you checks, it is your responsibility to deliver them to our office.

"I hereby authorize you to furnish information to my insurance company concerning my care. I further hereby assign all insurance payments for services rendered to me or my dependents".

My signature below indicates that I have read and, understood and comply with the SIGNATURE ON FILE, HMO/PPO LIMITATION OF LIABILITY AND FINACIAL POLICY.

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. This form will be retained in your medical records.

I acknowledge that I have received and had the opportunity to review the Notice of Privacy Practices on the date below and on behalf of Clark Road Chiropractic Center.

I understand that the Notice describes the uses and disclosure of my protected health information by Clark Road Chiropractic Center and informs me of my rights with respect to my protected health information.

My signature below stands proof that I give Clark Road Chiropractic Center my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Notice of Privacy Practices.

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

- Patient refused to sign
- Due to an emergency situation, it was not possible to obtain acknowledgement
- Communication barriers prohibited obtaining acknowledgement
- Other (please specify): _____

Employee Name (print): _____

Employee Signature: _____ Date: ___/_____/_____

PATIENT'S NAME (print): _____ Date of Birth: _____/_____/_____

Name of person authorizing treatment of MINOR or DEPENDANT (print): _____

PATIENT/GUARDIAN'S SIGNATURE: _____ DATE: ____/_____/_____| 6