Consent for Purposes of Treatment, Payment and Privacy

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.

Treatment

The nature of the chiropractic adjustment:
The primary treatment I use as a Doctor 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 "crack" your knuckles. You may feel a sense of movement.

Examination / Treatment
As a part of the examination and treatment, you are consenting to the following procedures: *(please initial)*

___Examination procedures:
-range of motion testing -palpation -postural analysis
___Treatments
-spinal manipulative therapy -hot/cold therapy -trigger point/massage therapy

The material risks inherent in chiropractic adjustment
As with any healthcare procedure, there are certain complications that 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. Every reasonable effort will be made 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 them.

The probability of those risks occurring:
Fractures are rare occurrences and generally result from some underlying weakness of the bone, which I 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 on 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 you condition 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 choose 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 that 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.

_____
initial

Payment

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

However, the patient or responsible party remains liable for any amount not paid by insurance, if any, within 30 days of our request for payment. In the event that payment is not timely made, and we must place the account for collections, you agree to pay all of our reasonable costs and expenses, including attorney fees, related to the collection of any sums due including the 30% collection fee. A finance charge of 1.5% per month (Annual Percentage Rate 18.0%) will be added to the account, but the finance charge will not begin to accrue until thirty days after our request for payment.

I hereby authorize the doctor to treat my condition as they deems appropriate. The patient also agrees that he/she is responsible for all bills incurred at this office.

_____
initial

Privacy

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician. This protected health information relates to my past, present, or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I consent to the use or disclosure of my protected health information by Generations Chiropractic Wellness for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations at Generations Chiropractic Wellness. I understand that Dr. Bradley may refuse to diagnose or treat me if I do not consent to the use or disclosure of my protected health information for the above stated purposes.

(My signature on this document is evidence of this consent.)

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Generations Chiropractic Wellness is not required to agree to the restrictions that I may request. However, if Generations Chiropractic Wellness agrees to a restriction that I request, the restriction is binding on Generations Chiropractic Wellness and Dr. Bradley.

I understand that I have a right to review Generations Chiropractic Wellness's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices for Generations Chiropractic Wellness is provided on request at the front desk of this practice. Notice of Privacy Practices also describes my rights and Generations Chiropractic Wellness's duties with respect to my protected health information. Generations Chiropractic Wellness reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling Generations Chiropractic Wellness's office and request a revised copy to be sent in the mail or asking for one at the time of my next appointment.

I have the right to revoke this consent, in writing, at any time, except to the extent that Generations Chiropractic Wellness or Dr. Bradley has taken action in reliance on this consent.

Signature of Patient or Personal Representative	Date
Name of Patient or Personal Representative	Doctor's Name
Description of Personal Representative's Authority	Doctor's Signature