NORTH ST. PAUL CHIROPRACTIC

SIGNATURES PAGE

FINANCIAL INFORMATION:

Who is responsible for this account? □ Self □ Other: _____
Relationship to Patient: □ Spouse □ Parent □ Other: _____
Will you be using insurance? □ Yes □ No, I am self paying
Insurance Company: _____ Policy # _____ Group # _____

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the doctor to release all information necessary to secure payment of benefits.

_____ Date: _____
Responsible Party signature

Printed name: _____

NOTICE OF PRIVACY POLICY:

I understand that under the *Health Insurance Portability & Accountability Act of 1996 (HIPAA)* I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow up care with multiple healthcare providers who may be involved in my care either directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited. You may request restrictions on your disclosures. You may inspect and receive copies of your records within 30 days with a written request. In the future we may contact you for appointment reminders, announcements, and to inform you about our practice and staff.

I have read and understand your Notice of Privacy Policy. I understand that I may request a more complete description of the privacy policy, and that I may request, in writing, that you restrict how my personal information is used and disclosed.

_____ Date: _____
Patient signature

_____
Printed name

CONSENT FOR EMAIL & TEXT MESSAGES:

Please mark whether you would prefer to be contacted via phone calls, email, or text messages. (If you would prefer to receive text messages please list the phone carrier/provider as well. Thank You)

☐ Email _____
Email Address

☐Text Messaging _____ _____
Cell Number Carrier

☐CALL ONLY _____
Phone Number

I have read the above paragraph and consent to be contacted via the methods I have marked above.

_____ Date: _____
Signature of Patient or representative (if minor or incapacitated)

_____
Printed name of Patient

INFORMED CONSENT FOR CHIROPRACTIC CARE:

The doctor will use his/her hands or a mechanical device in order to adjust or move your joints. You may feel a "click" or "pop" similar to when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary therapies, such as hot or cold packs, electrical stimulation, or manual therapies may also be used.

As with any health care procedure, complications are possible following a chiropractic adjustment. Complications could include:

- Fractures of bone
- Ligamentous sprain / muscular strain
- Stiffness or soreness
- Dislocation of joints
- Injury to intervertebral discs, nerves or spinal cord
- Skin irritation or burns from ancillary therapies
- Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck.

The risks of complications due to chiropractic treatment have been described as rare, about as often as complications are seen from taking a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million, and can be further reduced by screening procedures used in this office.

I have read the above explanation of chiropractic treatment and risks. I have had the opportunity to have any questions answered to my satisfaction. Understanding said risks, I hereby give my consent for the recommended chiropractic treatment for myself, or on the patient below for whom I'm legally responsible. I intend for this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment in this office.

_____ Date: _____
Signature of Patient or representative (if minor or incapacitated)

_____
Printed name of Patient

_____
Witness to Patient's signature Date