INFORMED CONSENT FORM

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. If anything is unclear, please ask questions before you sign.

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.

Analysis / Examination / Treatment

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

- ☒spinal manipulative therapy
- ☒mechanical traction
- ☒palpation
- ☒range of motion testing
- ☒orthopaedic testing
- ☒vital signs
- ☒basic neurological testing
- ☒postural analysis
- ☒nutritional assessment
- ☒muscle strength testing
- ☒radiographic studies
- ☒Instrument-Assisted Soft-Tissue Mobilization
- ☐Other ___________________________

The material risks 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. I 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 me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which Corrective Chiropractic will 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 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.

Open Adjusting Rooms

We keep an open environment in the office to create a sense of warmth, family, healing, and education. During adjustments, we do not go over private information; however, you will be in an open area where others may see you and/or overhear conversation. If there is a need to discuss something of a personal or private nature, you should request an appointment outside of regular adjusting hours or a phone call.

To Family and Close Friends Involved in Your Care

Our office has an open, family-centered approach to wellness and we believe it is in all our patient’s best interests to have the support and cooperation of their families. Therefore, our office requests that the spouse or significant other be present when the doctor goes over the patient’s report and recommendations for treatment and wellness. If you object to the presence of your spouse or significant other at your report, please let us know immediately.

In addition, we may disclose your Personal Health Information (or PHI) to a family member or a close friend if those persons accompany you while you are receiving health care services; or if we determine that it is in your best interest so we can provide you with the best health care possible. We may also disclose your PHI to a family member or someone else who helps pay for your healthcare treatment.

Requesting Restrictions

You have the right to request a restriction in how we use or disclose your PHI. However, we are not required to agree to your request. For instance, if you request that your spouse or significant other not be present when the doctor presents your report to you, we will not agree to such request.

Nutritional Consent

According to the Federal Food, Drug and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG' is defined to mean: "Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease.

A vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy.

Although, a Vitamin, a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone.

Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as any primary treatment and or therapy for any disease or particular bodily symptom.

SIGNATURE____

I HAVE READ AND UNDERSTAND ALL OF THE ABOVE INFORMATION

Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and bio-mechanical processes of the human body.
Nutritional advice and nutritional intake may also enhance the stabilization of the eight (8) chemical components of the VSC (Vertebral Subluxation Complex).I hereby, attest to the following:

1. I fully understand that the Nutrition Consultant I am seeing in this office is not a physician, and I am not consulting for medical, diagnostic, or treatment procedures.
2. The services performed by the Nutrition Consultant are at all times restricted to helping me gain a better understanding of my degree of "health" (not disease), so I will have a greater self-awareness and be able to use a self-care program for daily living.
3. I understand that as a Nutrition Consultant the recommendations, discussion, sale of food, nutrition, nutritional supplements, vitamins or minerals, food grade herbs, or other nutrients as foods for special dietary use only pertains to the whole body concept of nutrition, and does not relate in the context of any specific ailment or condition.
4. The appointments do not involve the diagnosing, prognosticating, treating or prescribing of medicines or the treatment of disease, or any act which will constitute the practice of medicine in this state, for which a license is required.

Personal Health Information

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records.
We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.
You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.
You have the right to inspect and copy PHI that may be used to make decisions about your care. Usually, PHI includes medical and billing records. To inspect and copy PHI, you must submit your request in writing on the form provided by our Practice. We will usually respond to your request within sixty (60) days. If you request a copy of your PHI, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.
If we charge a fee, we will let you know the fee in writing, prior to making the copies, so that you can withdraw or modify your request before incurring a charge. In addition, we may charge to make copies of your record to send to another health care provider; if so, we will notify you in writing prior to making the copies.
We may deny your request to inspect and copy your PHI in certain circumstances. If you are denied access to your PHI, you may request that the denial be reviewed in certain circumstances. Another licensed health care professional chosen by the Practice will review your request and our denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

TESTIMONY

I hereby give Corrective Chiropractic the irrevocable right and permission to use photographs and/or video recordings of me on the Corrective Chiropractic and other websites and in publications, promotional flyers, educational materials, derivative works, or for any other similar purpose without compensation to me I understand and agree that such photographs and/or video recordings of me may be placed on the Internet. I also understand and agree that I may be identified by name and/or title in printed, Internet or broadcast information that might accompany the photographs and/or video recordings of me. I waive the right to approve the final product. I agree that all such portraits, pictures, photographs, video and audio recordings, and any reproductions thereof, and all plates, negatives, recording tape and digital files are and shall remain the property of Corrective Chiropractic.

AUTHORIZATION FOR PUBLICATION OF CASE STUDY

I, give Dr. Bret Wickstrom and Corrective Chiropractic, permission to publish, reproduce, and distribute, the attached Case Study, regarding my care. I am aware that the Case Study does NOT mention my name or address, but it does reflect my medical care, gender, age and medical history.
I have been told that the authors currently plan to submit the Case Study for publication in a medical journal, for educational purposes.
I will not be paid in any manner for use of the Case Study, as described above. I will not receive any royalties or other compensation in connection with any such publication or use.
I am not required to sign this form, and I may refuse to do so. My medical treatment and payment for healthcare at Corrective Chiropractic will not be affected by whether or not I sign this document.
I may withdraw this authorization for any future sharing at any time by notifying my attending physician in writing, but my withdrawal will not affect information that has already been shared or published. This authorization has no expiration date.

SIGNATURE____

I HAVE READ AND UNDERSTAND ALL OF THE ABOVE INFORMATION

Please take a moment to read over these policies before signing. These policies are intended for our patients to receive the best possible care.

1. *If you choose a corrective care plan:* Due to Insurance standards, discounts do not apply to the first 24 to 60 visits depending on your care plan. The majority of your financial investment will be applied to this portion of care (the discount is not prorated but written off towards the end of care).
2. If you are going to miss an appointment, please call ahead to let us know. Please reschedule your missed appointment within 24 hours and have it rescheduled within one week of it being missed.
3. If you are to go on vacation while your treatment is scheduled please let us know ahead of time so that you can make up the appointments a week in advance and/or the following week.
4. If you have a question for Dr. Wickstrom that requires more than a short answer, please tell the receptionist so that they can have Dr. Wickstrom contact you at a better time to answer your question without disruption or feel free to use Facebook or email to send your question so that it can be answered in a more timely manner.
5. I have read these policies and fully understand that any savings that occur are applied to the END of my care plan. Charges for services rendered are for the first portion of care. If either you or your doctor should stop care before the care plan is completed, you may not receive a refund providing all have been depleted.

Your care plan is based on our extensive experience with cases of this nature as well as proven clinical trials.[1] Yet, during the course of treatment, there may be a need for a more or lesser level of treatment, decreased duration, or decreased frequency. Should any occur, your care plan will be modified accordingly.

IMPORTANT DISCOUNT NOTICE: The discounts offered to our patients for payments in advance are in no way present to induce patients to select us as their doctor nor are they designed to be a method of encouraging care. These pre-payment discounts dramatically reduce administrative costs and eliminate non-payment hazards. We then pass this savings on to you which reduces your out of pocket expenses, reduces wait time getting in and out of your appointments, and allows you to focus on your care.

Payment plans are not time arrangements. You will never owe for any services that were not provided for you. At the same time, monthly payment plans are there to help you better afford your care. You will either owe for services rendered, not months, or receive a refund (if funds have not been applied to the first 24 – 60 visits) if you should decide to stop treatment or be released from care prior to the end of the adjustment schedule.

6. Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. Exams, x-rays, adjustments, taping, therapies, traction, Graston, extremity adjustments and nutrition are separate and are never combined charges unless advertised or part of a treatment plan. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I understand that I have the right to revoke this authorization, in part or in whole, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that Corrective Chiropractic will only accept an original copy of written request to revoke by mail or in person.

I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Bret M. Wickstrom 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.

Patient's Name______________________________________ **Doctor's Name** Dr. Bret Wickstrom

Signature ____ **Dated** ______________________

Signature of Parent or Guardian(if a minor)

[1] Non-Randomized Control Trials; As seen on ideal Spine.com, Don Harrison, D.C. Five CBP® Case studies are in press at JMPT, while the six CBP® Clinical Control Trials are published/accepted/in review at JMPT (2), Archives of Physical Medicine and Rehabilitation (2), the (USA Veterans Administration journal) Journal of Rehabilitation Research and Development, and the European Spine Journal.