CORRECTIVE CHIROPRACTIC INFORMED CONSENT

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.

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
- physical therapy

This office's policies and procedures for initial treatment requires imaging (taken within last 3 months) of the area of complaint or where treatment will be administered. Our office will use images for 3 years as long as there are no new traumas or injuries.

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 a stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The doctor 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 attention, it is your responsibility to inform your doctor(s).

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 conversations. 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 of our patient's best interests to have the support and cooperation of their families. Therefore, our office encourages 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 (45 CFR 164.510(b)). You are permitting Corrective Chiropractic disclose your PHI to a family member or someone else who helps pay for your healthcare treatment.

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 and pain-killers
- 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.

REQUESTING RESTRICTIONS

You have the right to request a restriction on how we use or disclose your PHI. However, we are not required to agree to your 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.

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 I am not consulting for medical, diagnostic, or treatment procedures for a specific disease.
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 Corrective Chiropractic 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.

Your Rights
Civil rights are personal rights guaranteed and protected by the U.S. Constitution and federal laws enacted by Congress, such as the Civil Rights Act of 1964 and the Americans with Disabilities Act of 1990. Civil rights include protection from unlawful discrimination. Under these laws, all persons in the United States have a right to receive health care and human services in a nondiscriminatory manner.

Our Non-Discrimination Statement
Corrective Chiropractic complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This practice does not exclude people or treat them differently because of race, color, national origin, age disability, or sex. This practice:

- Provides information to patients in plain language and in a manner that is accessible and timely.
- Provides free services to people with disabilities to communicate effectively with us, including auxiliary aids.
- Provides free language assistance services to people whose primary language is not English.

If you need these services, contact our Practice's Compliance Officer, Liebe Wickstrom.
If you believe that Corrective Chiropractic has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Compliance Officer**.** You can file a grievance in person or by mail, or fax. ***4320 East 10th Street, Greenville, NC 27858 252-624-0729***

If you need help filing a grievance our Compliance Officer is available to help you.
You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

TESTIMONY
If I give a 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 print, 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, any Case Study that I am the subject of, or regards 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 participate 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 consent to participate in the Case Study.

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.

Waiver and Release & Assumption of the Risk

Corrective Chiropractic has put in place preventative measures to reduce the spread of COVID-19; however, Corrective Chiropractic cannot guarantee that you will not become infected with COVID-19 or Any other Viruses or be exposed to someone who has been infected with COVID-19. Further, being present at Corrective Chiropractic could increase your risk of contracting COVID-19. You acknowledge the inherent risks associated including but not limited to the possibility of personal contact with those who or may be infected with COVID-19 or any other viruses. The responsibility and decision to enter Corrective Chiropractic property is yours alone.

You hereby expressly and specifically assume the risk of injury or harm and does hereby release and forever discharge and hold harmless Corrective Chiropractic and its successors and assigns from any and all liability, claims, and demands of whatever kind or nature, either in law or in equity, which arise or may hereafter arise from your presence at Corrective Chiropractic. You understand that this Release discharges Corrective Chiropractic from any liability or claim that you may have against Corrective Chiropractic for any bodily injury, personal injury, disability, illness, and/or death that may result or in any way be related to your physical presence at Corrective Chiropractic property.

Responsibilities of Entrant

The Entrant, by signing this document, and in the future by entering Corrective Chiropractic Office, certifies that:

1. The Entrant is not currently experiencing any of the symptoms of COVID-19 (including, but not limited to cough, shortness of breath, difficulty breathing, fever, chills, muscle pain, sore throat, new loss of taste or smell).
2. The Entrant has waited 5 days after receiving any vaccine before entering Corrective Chiropractic Office.

PAYMENT POLICY

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 an account is not paid within 60 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest 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.

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I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional collection services will become immediately due upon suspension or termination of my care or treatment. (Fees: $100 Administration Fee and 30% Collection Fee of total balance due)
I (we), the undersigned, authorize and request Corrective Chiropractic to keep my credit/debit card information on file as a convenient method of payment for the portion of services that my insurance does not cover, but for which I am liable. Corrective Chiropractic may charge my credit card for balances due for services rendered that my insurance company identifies as my financial responsibility. Once my treatment has reached MMI Corrective Chiropractic will no longer bill insurance, however a statement will be provided to turn into your insurance for possible application to your out of network deductible or for tax purposes.
I understand that my credit card information will be kept confidential and secure and that payments will be processed only after the claim has been filed and processed by my insurer, and the insurance portion of the claim has paid and been posted to my account.
This authorization relates to all payments not covered by my insurance company for services provided to me by Corrective Chiropractic. This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60-day notification to Corrective Chiropractic in writing and the account must be in good standing.

Please take a moment to read these policies before signing. These policies are intended for our patients to receive the best possible care.
1. Appointment Cancellation: If you need to cancel an appointment, please call us in advance. Missed appointments should be rescheduled within 24 hours and completed within one week.
2. Doctor Communication: For detailed questions, inform the receptionist to schedule a call with the doctor or use text/email for timely responses.
3. Your care plan is based on our extensive experience with cases of this nature as well as proven clinical trials. 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.
4. Membership Discounts: Membership discounts are not meant to influence your choice of doctor but aim to reduce administrative costs and offer savings to you.
5. Returning Medical Equipment: There are no refunds of opened items. Opened or used items, such as pillows and supplements, cannot be returned due to health regulations.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND ALL OF 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 adjustments, related treatments, and office policies. I understand I will be able to discuss any concerns with Dr. Bret M. Wickstrom and have any questions answered to my satisfaction before any treatment is administered. 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 any risks, I hereby give my consent to that treatment.

Doctor's Name: Dr. Bret Wickstrom

Patient's Name: _____ DOB: _____

Patient/Representative Signature_____Date:_____

Witness Signature_____Date:_____