Informed Consent Document

Patient Name: ____

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 adjustment

The primary treatment I use as 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
- Range of Motion Testing
- Muscle Strength Testing
- Palpation
- Orthopedic Testing
- Postural Analysis
- Hot/Cold Therapy
- Vital Signs
- Basic Neurological Testing
- EMS (Electric Muscle Stimulation)*

*Please inform the doctor if you are being treated for cancer before using EMS.

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. 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 I check for during the taking of your history and during examination. 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.

Informed Consent Document (continued)

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 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, 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 have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed this with the doctor(s) or have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risk 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 be treated.

Dated:____________________

____

Patients Name (Please Print)

____

Signature

____

Signature of Parent or Guardian (if a minor)

CHIROPRACTIC DOCTOR/S OF FRONT STREET CHIROPRACTIC
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such and quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:____

Relationship to Patient:____

Signature:____

Date:____

____

____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date:____________________

Reason:____

____

____

Signature:__________________________

Financial Policy

We find that our clients appreciate knowing in advance what is expected of them financially and what terms and conditions are available. Please read the following information carefully. If you should have any questions please direct them to our Front Desk Staff. All patients are free to choose between the Necessary Paperwork Plan and the Paper Reduction Plan for their financial policy with Front Street Chiropractic.

DEFINITION:
Necessary Paperwork: (Third Party Pay / Insurance)
This fee schedule is higher than the Paperwork Reduction Plan, as necessary paperwork is inevitable when insurance is billed. Charges are billed either to the patient, another party, or an insurance company.

Paperwork Reduction: (Private Pay)
Under this payment method, charges for services are paid in full immediately after they are delivered, and no paper work is performed, other than a receipt. We accept Cash, Check, Visa, MasterCard or Discover as payment

ADMINISTRATIVE SERVICES THAT ARE NOT COVERED:
Since a reduced fee is charged for services, no documents will be supplied to the patient for reimbursement by a third party, including copies of medical records, completion of forms or questionnaires, writing of report, preparation of insurance bills, etc. However, a receipt will be given at the time of payment.

IF ADMINISTRATIVE SERVICES ARE REQUESTED:
If any of the previously mentioned documents are requested subsequent to payment of the reduced fee, the difference between the reduced charge and the billed charge will be paid by the patient (on all related services) prior to the preparation of the documents.

THIS PAPER REDUCTION PLAN IS SET BY THE CLINIC AND IS ONLY IN EFFECT AS LONG AS YOU ARE KEEPING THE SCHEDULE THE DOCTOR HAS SET FOR YOUR CARE. IF YOU REPEATEDLY MISS APPOINTMENTS AND DO NOT ADHERE TO THE SCHEDULE THE DOCTOR HAS SET FOR YOU, YOU WILL NOT BE ELIGIBLE FOR THIS PLAN.

REQUIREMENTS TO RECEIVE THE PAPER REDUCTION FEE SCHEDULE:
1. Keep the schedule the doctor sets for you.
2. Pay at the time of service.
3. Never carry a balance.
4. Require no paperwork from our financial department, only a receipt at the time of your service.

INSURANCE:
For most patients who carry insurance, you must bring a completed insurance form or card with you each time you are treated in our office. As a courtesy, this office will file a claim for your treatment with your insurance company and will accept assignment of benefits providing you pay all patient deductibles and estimated percentages at the time of your visit. We accept no responsibility in collecting overdue insurance claims or negotiating settlement on disputed claims. You are responsible for the total charges or any difference remaining following payment by your insurance company. If your insurance has not made payment or you feel that your insurance company has not made correct or adequate payment on your account, you must contact them first to discuss the matter. Please request that your insurance company provide you with a confirmation number as a record of your follow-up with them. We will not resubmit claims until this has been done.

PATIENT PAYMENT:
As a condition of treatment by this office, all patient portion of fees must be paid at the time the service is provided. Payments may be made by Cash, Check, Visa, MasterCard, or Discover Card. Any other payment arrangements must be authorized in advance by our Business Office.

COMPLEX NARRATIVE REPORTS:
These reports, as needed in litigation, are expected to be compensated by the party that requests the report. The terms will be agreed upon prior to the preparation of the report.

APPOINTMENT COMMITMENT:
When we schedule an appointment for you, two events occur: 1) We will hold that appointment time for you, and 2) we trust you will arrive ON TIME for that appointment. If you are late for an appointment, we will do our best to fit you into our schedule, however, it may be necessary to reschedule your appointment. Our policy is that the first time an appointment is missed we will give a warning of a fee. The second time this occurs you will be charged a fee of $25. If subsequent appointments are missed or cancelled with short notice you may be discharged from our practice.

IF YOU WISH TO BE BILLED;
You will have 30 days from the date of your statement to pay your bill in full without being charged interest.
A rate of 1.75% interest will be added to the balance each month thereafter. This amounts to 21% on a yearly basis.

Front Street Chiropractic
901 Front Street, Suite 120
Louisville, CO 80027
Phone 303-604-2987
Fax: 303-604-2997

PATIENT FINANCIAL POLICY

Patient Name____

Account Number_________________ Effective Date______________________

I understand that my chiropractic care in this office may vary in cost, depending on what services I receive.
The policy I choose is: (Please mark one.)

THE NECESSARY PAPERWORK PLAN: _______
THE PAPER REDUCTION PLAN: _______

TYPICAL BASIC SERVICES:

A. **Initial Consultation**
B. **Exams and Re-exams**
C. **Chiropractic adjustments**
D. **Physiotherapy**
E. **Exercise programs**

Qualifications for Paperwork Reduction Plan

1. No paperwork other than a receipt at the time of service is provided.
2. Payment in full is made each visit.
3. Never carry a balance on your account.
4. Keep your appointments and the schedule set by your doctor.

OUR NORMAL FEE SCHEDULE	PAPER REDUCTION FEE SCHEDULE	
01/2011 Fees subject to change		
Spinal adjustment………….$74.00	Spinal adjustment……………………………………… (Spinal Adjustment with some soft tissue work)	$45.00
Therapies……..……$25.00-$75.00	Attended Therapies (soft tissue, flexion/distraction)	$5.00-$50.00
	Unattended Therapies…(roller table, EMS)……….	$12.00
Initial Exam……..$50.00 - $155.00	Initial Exam………………………………….	$30.00 - $75.00
	Family Wellness Plan (adjustment only)… *(Both visits must occur in same Mon.-Fri. period)*	
	1st adult adjustment……..	$45.00
	2nd adult adjustment ……	$30.00
	Child adjustment (under 17)……………………………..	$30.00
Emergency Visit …$50.00-$100.00	Emergency Visit ……………………… ….	$50.00-$100.00
Missed Visit ……………..… $25.00	Missed Visit …………..…………………………..	$25.00

I authorize all insurance companies, third party payers and attorneys to make direct payment of my benefits to Front Street Chiropractic Center for all monies due my account for the services I have received. If my policy prohibits assignment, I direct my insurance company to mail all checks made payable to me, directly to Front Street Chiropractic, at 901 Front Street, Suite 120, Louisville, CO 80027.

______________________________ ______________
Patient / Authorized Signature Date

Updated 08/2011

Verifying Your 2011 Insurance Coverage

Patient Name:____

Please take a moment to contact your insurance carrier and verify your 2011 Chiropractic coverage. Even if your carrier has not changed, your benefits may have. Below is a list of questions to ask.

Date:__________________ Time:___________________

Name of insurance company:_____________________________________

Person you spoke to:____

Patient Insurance ID#:___________________ Group #:________________

Is Front Street Chiropractic an in-network provider? Yes ___ No ___

What is my Chiropractic coverage and limitations in their office? (Remember, we need either the in-network or out-of-network coverage on our status with your carrier.)

Calendar Year Deductible: ______________ Amount met this year-to-date: ______________

How much do I pay per visit? _______________________

Yearly limits to benfits:____

Address to send to claims: _______________________________
____
____
____

Please bring your insurance card with you so we may photocopy it. Thank you!

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