ALBERT LEA CHIROPRACTIC

Dr. Douglas J. Edwards
1340 West Main Street
Albert Lea, MN 56007 Phone: (507)377-3780

Informed Consent – Chiropractic Care

This notice describes what a patient may expect as it pertains to chiropractic treatment at this facility and indicates the patient's consent to propose to a course of care. Please review it carefully.

Chiropractic Care and Treatment:

I have had an opportunity to discuss with the chiropractic doctor, or other office personnel, the nature and objective of chiropractic care, the physical examination and other diagnostic tests and procedures used by chiropractors, including any necessary orthopedic, neurological laboratory tests, imaging studies (x-rays, CT scans, MRI's, etc.) and other procedures. Chiropractic care and treatment protocols, including chiropractic adjustments, manipulation, mobilization, and other therapies utilized by this facility and the care of my condition. Furthermore, it has also been communicated to me that I understand that every patient reacts differently to care, and that treatment results and outcomes cannot be guaranteed.

The Nature of Chiropractic Treatment:

I have been informed that on occasion, some patients experience increased discomfort following chiropractic care and treatment. Chiropractic physical examination and treatment may involve bending, twisting, mechanically challenging your joints and testing your muscle strengths, and it can possible lead to temporary feelings of soreness of pain. During the treatment, the doctor may use his/her hands or mechanical devices to move, adjust, manipulate your joints and mobilize soft tissues (example: muscles and ligaments). A crack (pop sound) is often produced in some of the joint manipulation procedures and popping sound when it is removed from glass of other smooth surfaces. Although a popping sound is not necessary, it is often a natural effect of a joint movement.

Permission for Physical Contact:

It has been explained to me and I understand that, in the course of various chiropractic examination procedures and treatment methods, the doctor of chiropractic or other clinical staff may have to examine and physically contact portions of my body. I hereby request, consent and submit to the chiropractic examination and treatment methods deemed necessary by the doctor.

Risk of Chiropractic Care and Treatment:

I understand and have been informed that there is a risk of side effects and complications anytime the doctor, provider or other clinician is asked to intervene in a healthcare encounter with a patient. I have been informed by this facility of the following: that although the risk of serious complication from chiropractic treatment is rare and unlikely, events ranging from relatively minor muscle soreness, aches, sprains and

strains to the spinal disc, nerves and spinal cord, or an occasional fracture or dislocation in compromised patients with certain concomitant diseases and illnesses have been reported in scientific literature. Cerebral vascular accidents such as stroke have also been reported; these are generally attributed to an underlying defect in a vertebral or basilar artery known as a spontaneous dissection and that these have been estimated to occur in 1 (one) to 500,000 up to 1 (one) in 40,000,000 cases of chiropractic, osteopathic, physical therapy and medical manipulation. This is about the same probability of stroke from turning your head or having your hair washed in a salon (a beauty parlor stroke).

It was explained to me that I do not expect the doctor to be able to anticipate all of the potential risks or complications. Nor do I expect that the doctor of other clinician to provide me with assurances that I will not experience a negative outcome. Nonetheless, I wish to rely on the doctor to exercise his/her best professional judgment during the course of the chiropractic examination and treatment which the doctor feels is in my best interest, based upon the facts known at the time.

It was explained to me that the most common and likely side effect of treatment will be the muscular stiffness or soreness described by some as a kind of ache people experience after exercising the first time in a long time, and that these effects are often transient and temporary. I was instructed that if I experience any increased discomfort following treatment that I should apply cool packs and rest the affected area. I was also told that if I become concerned about any treatment discomfort or, I should develop any new or unrelated symptoms, I should call Dr. Edwards or Dr. Sahr at the clinic, 507-377-3780, or his home at 507-377-0590. I also understand that if for some reason I am unable to reach Dr. Edwards or Dr. Sahr, their staff, or fill-in chiropractor, that I should telephone my personal, primary care doctor or present myself to the nearest hospital emergency room.

Consent:
By signing below, I acknowledge that I have read and understand the above consent and have had the opportunity to ask questions about its content and meaning. By signing below I agree to submit to the chiropractic examination and treatment methods. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek examination and treatment from Albert Lea Chiropractic. After having the information explained to me, I hereby request, consent and submit to the suggested examination and course of care.

Signature_____ Print_____ Date_____

ALBERT LEA CHIROPRACTIC
1340 West Main St.
Albert Lea, MN 56007
507-377-3780

(Consent to use PHI) Notice of Privacy Practices - Acknowledgement & Consent

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Albert Lea Chiropractic or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

_____ _____

Patient or Legally Authorized Individual Signature ***Date***

_____ _____

Print Patient's Full Name

_____ _____

Witness Signature ***Date***

ALBERT LEA CHIROPRACTIC OFFICE PROCEDURES

In order to be compliant with the new HIPAA (Health Insurance Portability and Accountability Act) Law, it is our responsibility to inform you of our office procedures.

1) We will address you by first name, last name or possibly both.
2) We require a minimum of a 4-hour notice when canceling an appointment. If a patient "no shows" (misses an appointment without canceling in advance) we reserve the right to charge a $30.00 fee and/or refuse to treat that individual. We do understand that emergencies unfortunately happen and this fee will be waived under those circumstances.
3) We will get verbal authorization from all new patients and renewals to confirm appointments and leave a message if patient is not available. Also, due to the amount of time we allow for our new patients, we require a minimum of a 12-hour notice to cancel the appointment. If appropriate notice is not given we reserve the right to charge the patient up to $40.00. We do understand that emergencies unfortunately happen and this fee will be waived under those circumstances.
4) We may need to call you regarding medical issues. What two numbers would you like us to call you at;_____ and _____. If we cannot reach you at these numbers, may we leave a message on your answering machine or with the person answering the phone? Yes_____ No_____
5) We may share protected health information with consulting physicians. We will only exchange minimum necessary protected health information.
6) We may send out postcards and/or e-mails reminding you of appointments or other needs.
7) Co-pays must be paid prior to services rendered.
8) That all patients understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and their member, and that ultimately, the patient is responsible for payment of any and all services, accumulated interest, and/or durable goods covered or non-covered.
9) If it becomes necessary to turn this account over to a collection office or a third party for payment, the patient will be responsible for all legal and collection fees.
10) All durable goods such as pillows, orthotics, vitamins, exercise equipment, and cold packs must be paid for prior to leaving the office.
11) We will submit charges to your primary insurance company. Submissions of secondary insurance policies are the responsibility of the patient. If you have Medicare and a supplement that does not automatically cross over, you will need to bring in your explanation of benefits from Medicare so that we may make a copy to send to your supplement.
12) We must receive changes of insurance information or new insurance cards at the time of service. If this information is not received at that time, the patient will become responsible for submitting those claims to their insurance company.
13) We will do everything we can to protect your patient health information.

Please keep in mind our office was designed before the HIPAA Law so please be respectful of other patients' privacy. Is there anyone you would like us to discuss your healthcare or billing with? If so please list them below.

_____ We will be unable to discuss your treatment, appointments, or billing with anyone not listed above, this includes your spouse, children or any other family members.

I,_____, agree to all of the above office procedures of Dr. Douglas J. Edwards and Albert Lea Chiropractic, and give my authorization to all of the above procedures.

Patient:_____ Date:_____

Today's Date _____

Chiropractic Intake & History

Albert Lea Chiropractic
1340 West Main Street
Albert Lea, MN 56007
507-377-3780

First Name: _____ Last Name: _____MI: ____ Date of Birth_____

Address: _____City:_____ State: _____ Zip: _____

SSN: _____ Sex: ☐ M ☐ F Age ____ E-mail _____

Primary Phone: _____ Cell Phone: _____

Employer: _____ Occupation: _____

☐ Married ☐ Widowed ☐ Single
☐ Separated ☐ Divorced ☐ Minor (Under 18)

Spouse's Name: _____
Spouse's Employer _____
Number of Children_____

Demographics:

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ African American
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Decline to Provide

Smoking Status:

- ☐ Never
- ☐ Former Smoker
- ☐ Daily Smoker
- ☐ Occasional Smoker

Do you prefer text message or email appointment reminders? _____

IN CASE OF EMERGENCY / PERSON TO CONTACT

Name: _____ Relationship: _____

Contact Number: _____

What made you decide to come here? _____

Main reason for visit: _____

How did it happen? _____

Date you first notice this problem: _____

None…….to…….Severe

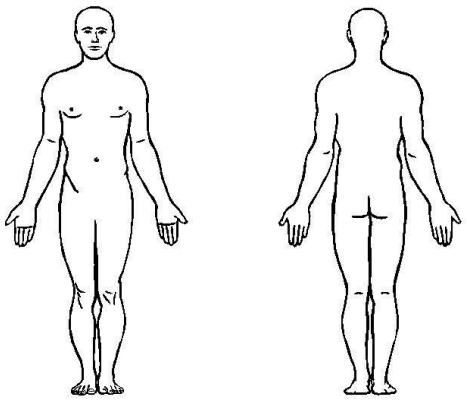
Rate your pain at its BEST 0 1 2 3 4 5 6 7 8 9 10

Rate your pain at its WORSE 0 1 2 3 4 5 6 7 8 9 10

How often during the day do you notice the pain?

☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

Please check the box that best describes whether your pain or symptom(s) limit normal activities.



Activity:	Normal	Limited	Severely Limited
Lifting	☐	☐	☐
Bending	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐
Sitting	☐	☐	☐
Climbing Stairs	☐	☐	☐
Run/Jog	☐	☐	☐
Resting in Bed	☐	☐	☐
Computer Work	☐	☐	☐
Other_____	☐	☐	☐
Other_____	☐	☐	☐

Does anything make your pain better? Hot Cold Medication Other: _____

_____

Currently are you experiencing any of the following (circle all that apply):

General:
Fever
Chills
Night Sweats
Change in Appetite
Fatigue
Weight Gain
Weight Loss

Cardiovascular:
Chest Pain
Palpitations

Urinary:
Painful urination
Urgency
Frequent urination
Blood in urine

Eyes:
Blurred Vision
Visual Loss
Dry Eyes
Pain
Discharge

Respiratory:
Shortness of Breath
Cough
Wheezes
Sputum

Neurologic
Fainting
Memory loss

ENT & Mouth:
Congestion
Sore Throat
Ear Pain
Drainage
Dental Pain

Skin:
Rashes
Bruising
Blisters
Itching
Dryness
Hair Loss

Gastrointestinal:
Nausea
Vomiting
Abdominal Pain
Diarrhea
Constipation
Pain with Bowel Movements

Psychiatric:
Tearfulness
insomnia
Hallucinations
Suicidal or homicidal thoughts

☐ **None Apply**

Personal History – The following lists a variety of conditions that patients may experience. Please read through the list and check all conditions that apply to you.

Pain in Body
- ☐ Neck pain with difficulty swallowing
- ☐ **Electric shocks** in arms and legs when moving neck **with** extreme neck stiffness and pain
- ☐ Leg pain that worsens with exercise but is relieved by resting
- ☐ Loss of feeling in inner thighs
- ☐ Urinary problems **with** back pain

Current Conditions
- ☐ Unable to balance when walking
- ☐ Recent unexplained weight loss
- ☐ Resent progressive muscle weakness or shaking
- ☐ Recent current fever over 102°
- ☐ Loss of bowel or bladder control
- ☐ Blurred or double vision, dizziness nausea or faintness when neck is in certain positions

- ☐ Recent major accident such as fall from height, whiplash, or blow to the hea

Types of Pain
- ☐ Severe pain interrupts sleep
- ☐ Constant pain that doesn't improve by changing positions or lying down

☐ **None Apply**

Previously diagnosed condition/ medical history
- ☐ Congenital bone or joint disorder
- ☐ History of compression fracture
- ☐ Past history of cancer or currently diagnosed with cancer
- ☐ Ankylosing spondylitis
- ☐ Lupus
- ☐ Rheumatoid arthritis
- ☐ History of heart attack
- ☐ Diabetes with cold, burning, or numb feet
- ☐ Immune suppression such as from Chemotherapy, organ transplant, etc
- ☐ Severe degenerative arthritis
- ☐ History of stroke or aneurysm
- ☐ Gout
- ☐ 3 or more months use of steroid medications or intravenous drugs (past or recent)

☐ **None Apply**

Other medical issue of any kind please list here (ie. Diabetes, heart disease, etc) _____

_____

_____

_____

_____

Family History: Do you know of anyone in your family with the following conditions?

☐ Autoimmune Disorders ☐ Cancer ☐ Heart Disease ☐ Mental Illness
☐ Arthritis ☐ Diabetes ☐ Kidney Disease ☐ Seizure Disorder

Do you sleep well? ☐ Yes ☐ No What are your normal sleeping hours? _____to _____

Are you currently under the care of a medical doctor or other type of health care provider for any condition? ☐ No ☐ Yes

For what condition_____

Name of doctor/ provider_____ Provider Location_____

Please list any surgeries or overnight stays in the hospital you have had: _____

_____

_____

Do you exercise? ☐ NO ☐ Yes → Please describe activity _____

How many days a week? _____ How many minutes per session?_____

Have you ever been to a chiropractor before? No Yes → Who? _____

When was the last time you saw a chiropractor? _____

Do you have any ALLERGIES of any kind? No Yes → To what? _____

Do you have a pacemaker, defibrillator, or other in body electronics? No Yes → What? _____

Do you use caffeine? No Yes → In what? _____Do you drink alcohol? No Yes → How Much? _____

Do you have a history of drug or alcohol addiction? No Yes

Do you have a disability of any kind? No Yes → What kind? _____

Do you feel you have stress at work or home? No Yes → Work Home Both

Do you have any special hobbies? _____

Do you have a history of: ☐ Diabetes ☐ High cholesterol ☐ High Blood Pressure
☐ Blood clotting disorder ☐ Stoke or Transient Ischemic Attacks
☐ Other: _____

Do you take: ☐ Oral steroids such as Prednisone ☐ Coumadin

Do you take medications? No Yes Please list them or **give us a copy** _____

_____

Have you ever been in a car accident? No Yes → How many? _____

Have you ever had a concussion? No Yes → How many? _____

Have you ever had any broken bones? No Yes → Where: _____

Additional Information: _____

_____

_____

_____

_____

I certify that the above information is true and correct to the best of my knowledge and I hereby consent to the release of my confidential medical and patient information in the possession of Albert Lea Chiropractic to other health professionals to whom I am referred and to the insurance company or the entity responsible for payment, utilization and / or quality review for all or a portion of my care.

I request payment of benefits from either a government or non-government source be paid directly to Albert Lea Chiropractic PLC. If I am utilizing my auto insurance I request my insurance carrier pay Albert Lea Chiropractic PLC directly for services provided at Albert Lea Chiropractic LPC and not me the patient personally.

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any services provided at Albert Lea Chiropractic. In the event that your account is balanced with a Collection Agency, a collection-fee in the amount of 50% of the then outstanding balance will be added to your account and shall become a part of the Total Amount Due. I understand that Albert Lea Chiropractic may contract with outside agencies for collections. I authorize Albert Lea Chiropractic, agents, collection agencies, or attorneys to contact me via autodialed or prerecorded message on my landline or my cell phone. If your account is subsequently placed with an Attorney for legal action, whether a law suit is actually filed or not, attorney's fees will be added in the amount equal to 25% of the balance of the date of placement with the attorney (including collection fees) and shall become part of the total Amount Due. Further, any account not paid within 30 days of the date-of-service, shall be subject to an account charge of 18% per annum (1.5% per month), or the maximum allowed by state law, this amount may be added to and become part of the Total Amount Due. Failure to add one or more of the above charges immediately, does not preclude us from adding any and all of the amounts to your Total Amount Due and any time in the collection process. Your account will not be considered "paid in full" until the total Amount Due, including any or all the above amounts, if applicable, are paid in full and funds have been released by your financial institution. In addition, any payments returned by your financial institution will be subject to the maximum service charge (and / or processing fees) allowed by law and you authorize us, or agents, agencies or other third-parties to collect this amount via electronic or paper draft to the amount of the original payment.

Signature: _____ Today's Date: _____

If the patient required assistance to complete, please sign name and state relationship (ex: parent, translator) below:

Name: _____ Relationship: _____ Today's Date: _____