

Great Day

Chiropractic & Rehab

For office use only:	
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Date entered in CT:	_____
CA initials	_____

Understanding Your Medicare Benefits

Please read this before proceeding with paperwork:

GOOD NEWS!

Medicare is likely to cover at least some of your chiropractic care. We prepared this brochure because Medicare handles chiropractic care differently from medical treatment. Here's how to take advantage of your chiropractic benefits under Medicare Part B.

YOUR COVERAGE

Medicare **ONLY** covers the cost of chiropractic adjustments in the spine. It does **NOT** cover hips, shoulders, knees etc. If you have a Medicare Replacement plan, your coverage may differ from traditional Medicare. We will help confirm your benefits.

THE EXAMINATION

Your chiropractor is required by law to perform examinations at the beginning and end of your treatment plan, however, Medicare does not pay for the cost of the exams or any needed X-rays.

YOUR RESPONSIBILITY

Regardless of the type of doctor you see, Medicare requires you to pay an annual deductible amount. Then, you'll be responsible for a 20% co-payment for the cost of each chiropractic adjustment. Medicare will pay the remaining 80% of the cost of adjustments that Medicare deems medically necessary. You are also responsible for 100% of all examination and re-exam fees. **Please ask a staff member about discounted pricing for uncovered fees.**

MEDICAL NECESSITY

For Medicare to pay for your adjustments, they must be "medically necessary." That means:

1. Your adjustments must relate directly to your specific health complaint,
2. Your adjustments must hold the promise of making functional improvements, and
3. You must follow your chiropractor's specific plan for active treatment.

FUNCTIONAL IMPROVEMENT

Instead of judging your progress simply by how you feel, Medicare wants to see improved function. That means a restored ability to turn, bend, walk, sleep and generally perform your daily activities. Once improvement stops, Medicare coverage stops. That's because they consider further care to be maintenance care and expect you to self-pay.

MAINTENANCE CARE

Medicare does not pay for chiropractic care to maintain your progress or help prevent problems. While most patients see the wisdom of some type of wellness care, Medicare does not pay for it. Recognizing the value of protecting their improvement, many opt to self-pay.

EXCLUDED SERVICES

We only recommend the care that is clinically appropriate. That might include other procedures such as massage, traction or other therapies. Medicare does not pay for these, nor do they pay for adjustments to your wrist, ankle or other extremity. Sometimes these procedures may be covered by any supplemental insurance you may have.

MAXIMUM IMPROVEMENT

The number of adjustments covered by Medicare varies. It's based on the severity of your condition(s). Sometimes, more visits will be needed than what Medicare will pay for. If continued care seems promising to you (but not Medicare), you may pay for the care yourself.

OUR PARTICIPATION

Our practice is a Participating Provider with Medicare. That means you'll pay any unmet deductible amount for the calendar year, plus a 20% co-payment for each chiropractic adjustment. We will bill Medicare and they will pay us directly. Because we are a Participating Provider, if you have supplemental insurance, it may assume some or all of your 20% co-payment and excluded services.

SIGNATURE

PRINTED NAME

DATE

CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential, We comply with all federal privacy standards.
Please print clearly.

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?

No Yes When? _____

Whom may we thank for referring you?

If so, whom?

Gender

Male Female

Your Last Name

How would you like to be addressed?

Your First Name

Your Middle Name (or Initial)

Birth Date (MM/DD/YYYY)

Your Age

Address

Marital Status

Single Married Divorced
 Widowed Separated

City

State

Zip/Postal Code

Home Phone

Spouse's Name

Email Address

Cell Phone

Child's Name and Age

Emergency Contact

Phone

Child's Name and Age

Your Occupation

Child's Name and Age

Your Employer

May we contact you at work?

No Yes

Address

City

State

Zip/Postal Code

Work Phone

Insurance Carrier

Policy Number

Primary Care Provider's Name

Insured's Last Name

Insured's Social Security Number

Insured's First Name

Middle Name (or Initial)

Who carries this policy?

Self Spouse Divorced

Insured's Phone Number

Insured's Date of Birth

Insured's Address

City

State

Zip/Postal Code

Employer's Phone

CONFIDENTIAL HEALTH INFORMATION

1. The symptom(s) that have prompted me to seek care today include: _____

Patient name

2. And are the result of (check box) An accident or injury
 Work Auto Other _____
 A worsening long-term problem _____
 An interest in: Wellness Other _____

All other systems negative

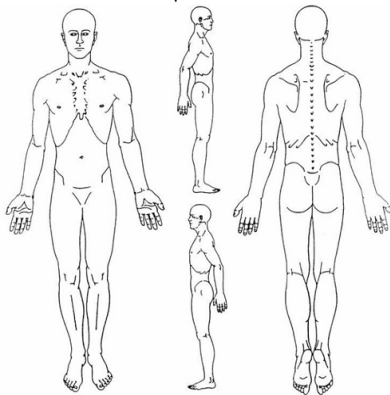
3. Onset (When did you first notice your current symptoms?) _____
4. Intensity (How extreme are your current symptoms?) _____
5. Duration and Timing (What % of the time do you feel symptoms?) _____



6. Quality of symptoms (What does it feel like?)

- Numbness
- Tingling
- Stiffness
- Dull
- Aching
- Cramps
- Nagging
- Sharp
- Burning
- Shooting
- Throbbing
- Stabbing
- Other _____

7. Location (where does it hurt?) Circle the area(s) on the illustration. "O" for current condition "X" for conditions experienced in the past.



8. Radiation (does it affect other areas of your body? To what areas does the pain radiate, shoot, or travel) _____

9. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to **worsen** the problem? _____
What tends to **lessen** the problem? _____

10. Prior Interventions (What have you done to relieve the symptoms?)

- Prescription Medication Surgery Ice
- Over-the-counter drugs Acupuncture Heat
- Homeopathic remedies Chiropractic Other _____
- Physical Therapy Massage _____

11. What else should we know about your current condition? _____

12. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

13. Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please mark the square beside any condition that you **Had** or currently **Have** and initial to the right.

a. Musculoskeletal

- | | | | | | | |
|--|--|--|---|--|--|-------------------------------|
| Had Have | Had Have | Had Have | Had Have | Had Have | Had Have | None <input type="checkbox"/> |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Back problems | <input type="checkbox"/> Hip disorders | Initials _____ |
| <input type="checkbox"/> Knee Injuries | <input type="checkbox"/> Foot/Ankle pain | <input type="checkbox"/> Shoulder problems | <input type="checkbox"/> Elbow/wrist pain | <input type="checkbox"/> TMJ issues | <input type="checkbox"/> Poor posture | |

b. Neurological

- | | | | | | | |
|----------------------------------|-------------------------------------|-----------------------------------|------------------------------------|---|-----------------------------------|-------------------------------|
| Had Have | Had Have | Had Have | Had Have | Had Have | Had Have | None <input type="checkbox"/> |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Headache | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Pins and needles | <input type="checkbox"/> Numbness | Initials _____ |

b. Cardiovascular

- | | | | | | | |
|--|---|---|---|---------------------------------|---|-------------------------------|
| Had Have | Had Have | Had Have | Had Have | Had Have | Had Have | None <input type="checkbox"/> |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Angina | <input type="checkbox"/> Excessive bruising | Initials _____ |

b. Respiratory

- | | | | | | | |
|---------------------------------|--------------------------------|------------------------------------|------------------------------------|--|------------------------------------|-------------------------------|
| Had Have | Had Have | Had Have | Had Have | Had Have | Had Have | None <input type="checkbox"/> |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Apnea | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Pneumonia | Initials _____ |

b. Digestive

- | | | | | | | |
|---|--------------------------------|---|------------------------------------|---------------------------------------|-----------------------------------|-------------------------------|
| Had Have | Had Have | Had Have | Had Have | Had Have | Had Have | None <input type="checkbox"/> |
| <input type="checkbox"/> Anorexia/bulimia | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Food sensitivities | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea | Initials _____ |

b. Sensory

- | | | | | | | |
|---|--|---------------------------------------|--|--|--|-------------------------------|
| Had Have | Had Have | Had Have | Had Have | Had Have | Had Have | None <input type="checkbox"/> |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Chronic ear infection | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Loss of taste | Initials _____ |

[Consultation Notes]

Doctor's initials

a. Integumentary

- Had Have Had Have Had Have Had Have Had Have Had Have None
 Skin cancer Psoriasis Eczema Acne Hair loss Rash Initials _____

b. Endocrine

- Had Have Had Have Had Have Had Have Had Have Had Have None
 Thyroid issues Immune disorders Hypoglycemia Frequent infection Swollen glands Low energy Initials _____

b. Genitourinary

- Had Have Had Have Had Have Had Have Had Have Had Have None
 Kidney stones Infertility bedwetting Prostate issues Erectile dysfunction PMS symptoms Initials _____

b. Constitutional

- Had Have Had Have Had Have Had Have Had Have Had Have None
 Fainting Low libido Poor appetite Fatigue Sudden weight change Weakness Initials _____

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

14. Illnesses

Check the illnesses you have Had in the past or Have now. (Please check all that apply)

- | | |
|--|---|
| Have Had | Have Had |
| <input type="checkbox"/> <input type="checkbox"/> AIDS | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> <input type="checkbox"/> Alcoholism | <input type="checkbox"/> <input type="checkbox"/> Typhoid fever |
| <input type="checkbox"/> <input type="checkbox"/> Allergies | <input type="checkbox"/> <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> <input type="checkbox"/> Cancer | |
| <input type="checkbox"/> <input type="checkbox"/> Chickenpox | |
| <input type="checkbox"/> <input type="checkbox"/> Diabetes | |
| <input type="checkbox"/> <input type="checkbox"/> Epilepsy | |
| <input type="checkbox"/> <input type="checkbox"/> Glaucoma | |
| <input type="checkbox"/> <input type="checkbox"/> Goiter | |
| <input type="checkbox"/> <input type="checkbox"/> Gout | |
| <input type="checkbox"/> <input type="checkbox"/> Heart disease | |
| <input type="checkbox"/> <input type="checkbox"/> Hepatitis | |
| <input type="checkbox"/> <input type="checkbox"/> Malaria | |
| <input type="checkbox"/> <input type="checkbox"/> Measles | |
| <input type="checkbox"/> <input type="checkbox"/> Multiple Sclerosis | |
| <input type="checkbox"/> <input type="checkbox"/> Mumps | |
| <input type="checkbox"/> <input type="checkbox"/> Polio | |
| <input type="checkbox"/> <input type="checkbox"/> Rheumatic fever | |
| <input type="checkbox"/> <input type="checkbox"/> Scarlet fever | |
| <input type="checkbox"/> <input type="checkbox"/> Sexually transmitted disease | |
| <input type="checkbox"/> <input type="checkbox"/> Stroke | |

15. Operations

Surgical interventions, which may or may not have included hospitalization.

- Appendix removal
 Bypass surgery
 Cancer
 Cosmetic surgery
 Elective surgery _____

 Eye surgery
 Hysterectomy
 Pacemaker
 Spine _____

 Tonsillectomy
 Vasectomy
 Other _____

16. Treatments

Check the ones you've received in the Past or are receiving Currently.

- Acupuncture
 Antibiotics
 Birth control pills
 Blood transfusions
 Chemotherapy
 Chiropractic care
 Dialysis
 Herbs
 Homeopathy
 Hormone replacement
 Inhaler
 Massage therapy
 Physical therapy
 Nutritional supplements
 List: _____

 Medications (prescription and over-the-counter)

17. Injuries – Have you ever...

- Had a fractured or broken bone
 Had a spine or nerve disorder
 Been knocked unconscious
 Been injured in an accident
 Used a crutch or other support
 Used neck or back bracing
 Received a tattoo
 Had a body piercing

Family History

Some health issues are hereditary. Tell us about the health of your immediate family members.

Relative	Age (If living)	State of health		Illnesses	Age at death	Cause of death	
		Good	Poor			Natural	Illness
Mother	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Father	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Sister 1	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Sister 2	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Brother 1	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Brother 2	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

19. Are there any other hereditary health issues that you know about? _____

20. Social History

Tell us your health habits and stress levels.

- | | | | | |
|----------------|--|-----------------|-----------------------|--|
| Alcohol use | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly | How much? _____ | Prayer or meditation? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Coffee use | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly | How much? _____ | Job pressure/stress? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Tobacco use | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly | How much? _____ | Financial peace? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Exercising | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly | How much? _____ | Vaccinated? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Pain relievers | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly | How much? _____ | Mercury fillings | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Soft drinks | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly | How much? _____ | Recreational drugs? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Water intake | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly | How muc? _____ | | |
| Hobbies | _____ | | | |

PERSONAL

FAMILY

SOCIAL

[Consultation Notes]

Patient name

All other systems negative

Doctor's initials

21. Activities of Daily Living – Functional Rating Index

How does this condition currently interfere with your life and ability to function? (for each activity, circle the number that most closely describes your condition right now)

	No Affect	Mild Affect	Moderate Affect	Severe Affect	Worst Possible Pain		No Affect	Mild Affect	Moderate Affect	Severe Affect	Worst Possible Pain
Pain Intensity	0	1	2	3	4	Recreation	0	1	2	3	4
Sleeping	0	1	2	3	4	Frequency of pain	0	1	2	3	4
Personal Care (washing, dressing etc)	0	1	2	3	4	Lifting objects	0	1	2	3	4
Travel (driving, etc.)	0	1	2	3	4	Walking	0	1	2	3	4
Work	0	1	2	3	4	Standing	0	1	2	3	4

Score _____

22. What is the major stressor in your life? _____ 23. How much do you sleep on average per night? _____ Hours

24. What is the type and approximate age of your mattress and pillow? _____

25. What is your preferred sleeping position? _____

26. Describe your typical eating habits Skip breakfast Two meals a day Three meals a day Snacking between meals

27. What would be the most significant thing that you could do to improve your health? _____

28. In addition to the main reason for your visit today, what additional health goals do you have? _____

Acknowledgments

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement to the following:

Initials _____ I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials _____ I realize that an x-ray examination may be hazardous to an unborn child and I certify to the best of my knowledge I am not pregnant. Date of last menstrual period. _____

Initials _____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, e-mails or health information to me as an extension of my care in this office.

Initials _____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initials _____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

If the patient is a minor child, print the child's full name: _____

Signature _____

Date (MM/DD/YYYY) _____

Patient name

All other systems negative

[Consultation Notes]

Doctor's initials

FINANCIAL POLICY

At **Great Day Chiropractic & Rehab**, we understand that the cost of healthcare is a key concern for our patients. Although patient care is our main priority, we hope that you will assist us by understanding your responsibility as it relates to our Financial Policy. If you have any questions regarding our policy a member of our staff will be glad to assist you.

HEALTH INSURANCE

- As a courtesy to you, when given a copy of your insurance card, we will call and find out your benefits for chiropractic care in our office.
- We do not file claims for **acupuncture, massage, lab work, orthotics, supplements or merchandise** to your insurance.
- If you receive care that we do not file for, you will need to pay for the services rendered. If you would like to submit the charges yourself for reimbursement, we will be happy to make copy of your fee slip. Please remember-the benefits information your insurance company quotes us is not a guarantee of payment from them and any remaining fees are due immediately from you.

MEDICARE

- Medicare covers spinal adjustments only. After your yearly deductible has been met, Medicare should cover 80% of the allowed costs for adjustments. You will be responsible for the remaining 20%, as well as the cost for any non-covered services.
- You will be asked to fill out an advanced beneficiary notice for non-covered services.

SECONDARY INSURANCE

- Please inform us of any secondary insurance you may have. We will be glad to file chiropractic claims to your secondary insurance after your primary insurance has processed the claim(s).

AUTO ACCIDENTS AND MED-PAY

- If you've not already done so, please notify your auto insurance carrier of your accident immediately. We will have you fill out the proper document so we can file claims with your insurance carrier. We will call your adjuster together the information we need to file.
- If you reach the maximum amount payable under your auto insurance, we will file the claim that your health insurance. Although you are ultimately responsible for your Bill, we will do whatever we can to secure reimbursement from your insurance carrier. Once the claim is settled or if you suspend/terminate care against physicians recommendations, any remaining fees are due immediately from you.
- If there is a third party involved (such as an attorney), you'll be asked to make partial payments as care is received. Accepting assignment and/or liens is done so under a pre-qualified understanding between the patient, this office and the third party payor(s). Establishing an honest ethical working relationship allows this office to continue accepting liens and assisting patients in their goals for better health. Any and all changes of the original party's agreement, independent of this office's knowledge or consideration, immediately disqualifies the terms of that agreement and demands immediate payment on the outstanding balance.

PATIENTS WITHOUT INSURANCE

- We request that 100% of all visits be paid at the time of service.
- We gladly accept cash, checks, credit cards, HSA, and flex-pay cards.
- Our office has established a single-fee schedule that applies to all patients for each service provided based allowable limits determined to be reasonable and customary for the state of Colorado. We cannot offer "cash" or time of service discounts greater than 10% below these rates, however, we do offer discounts for members of discount groups such as ChiroHealthUSA. Discount members are entitled to discounts similar to insured patients. Membership is \$49.00 per year and covers you and your dependents. Ask a staff member for details if you are interested.

Changes to any appointment should be made 24 hours in advance to avoid a \$25 service fee. Reschedules should be confirmed and done directly with the front desk. The Doctor is the only one qualified to change your treatment schedule.

When you pay by check you expressly authorize this office, if your check is dishonored or returned for any reason, to electronically debit your account for the amount of the check, plus a processing fee of \$25 and any applicable sales tax. The use of a check for payment is your acknowledgment and acceptance of this policy and it's terms.

Financial arrangements are valid under your present condition. They are subject to renewal by the start of each New Year. Should changes arise in your medical or financial situation that would affect your current financial agreement, you must notify this office prior to your care. Should you discontinue care or be released from further service, at this office, all outstanding balances are due upon notification.

Any past due balance not paid **within 90 days** will be reported to the credit bureau and turned over to an attorney, small claims court, or agency for collections. You will be responsible for all charges related to this collection process. Please keep your account current to avoid any action or blemish on your credit history.

Thank you for your understanding of our Financial Policy. Please let us know if you have any questions.

Printed Name: _____

Signature: _____ Date: _____

PATIENT PRIVACY

This practice is committed to maintaining the privacy of your protected health information (PHI), which includes information about your health condition and the care you receive from the practice. This notice details how this information may be used in this office. With consent from you, it is the policy of this office to use the your PHI in the following manners:

1. Treatment: Your PHI will be given to those professionals that require it to provide care.
2. Appointment reminders: Our staff may call from time to time to remind you of appointments
3. Sign-in Log: We maintain a log of incoming patients for our own statistical use
4. Referral board: We keep a board to thank member of our practice who have referred others
5. Medical Doctors: It is the policy of this office to share our findings with your regular medical doctor. This helps build a better understanding of how we may work together to improve your health.

In special circumstances, your PHI may be disclosed as in the following:

1. Personal Representative: In accordance with applicable law that may represent you.
2. Emergency situations
3. Abuse, Neglect, or Domestic Violence
4. Law Enforcement issues
5. Worker's Compensation claim
6. Avert a health threat

Your rights regarding your health information:

1. Right to inspect and copy your records: A written request must be submitted and cost of copying may be applied to such a request
2. Amend your PHI by submitting a written request with an explicit reason.
3. Request restrictions on your PHI. However, this practice is not obligated to agree to any such restrictions.
4. Revoke consent at any time
5. Complain to the practice

Printed Name: _____

Signature: _____ Date: _____

CONSENT TO TREAT

The primary treatment used by doctors of chiropractic is the spinal adjustment.

We will use that procedure to treat you.

• The nature of the chiropractic adjustment.

We will use hands or a mechanical device 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 or sense movement.

• The material risks inherent in chiropractic adjustment.

As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include: fractures, disc injuries, dislocations, and muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. 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.

• The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and x-ray. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority¹ saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare."

• The availability and nature of other treatment options.

Other treatment options for your condition include:

- Self-administered, over-the-counter analgesics and rest
- Medical care with prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization with traction
- Surgery

The material risks inherent in such options and the probability of such risks occurring include:

- Overuse of over-the-counter medications produces undesirable side-effects. If complete rest is impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his pain tolerance and self-discipline in not abusing the medicine. Professional literature describes highly undesirable effects from long term use of over-the-counter medicines.
 - Prescription muscle relaxants and pain-killers can produce undesirable side effects and patient dependence. The risk of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his pain tolerance, self-discipline in not abusing the medicine and proper professional supervision. Such medications generally entail very significant risks — some with rather high probabilities. • Hospitalization in conjunction with other care bears the additional risk of exposure to communicable disease, iatrogenic (doctor induced) mishap and expense. The probability if iatrogenic mishap is remote, expense is certain, exposure to communicable disease is likely with adverse result from such exposure dependent upon variables.
- ¹ Haldeman, Scott, D.C. M.D.
- The risks inherent in surgery include adverse reaction to anesthesia, iatrogenic (doctor caused) mishap, all those of hospitalization and an extended convalescent period. The probability of those risks occurring varies to many factors.

• The risks and dangers attendant to remaining untreated.

Remaining untreated allows the formation of adhesions and reduces mobility which sets 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. The probability that non-treatment will complicate a later rehabilitation is very high.

Do Not Sign Until You Have Read And Understand The Above.

Please Check The Appropriate Block and Sign Below:

I have read [] or have had read to me [] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with my Doctor of Chiropractic 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 myself 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.

Dated: _____ Printed Name

Signature

Witnesses: _____ Signature of Parent or Guardian (if a minor)

Printed Name

Signature