# Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. It is important that each patient understands both the objective and the method that will be used to attain it. It is the patient's responsibility to inform the doctor all information pertaining to their health accurately and entirely including any changes that may be experienced during the course of treatment.

**Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

**Health:** A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

**Vertebral Subluxation:** A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

**Analysis, Examination, and Treatment:** Prior to receiving chiropractic care from Tilson Chiropractic FamilyCare, a health history and physical examination will be completed.These procedures are performed to assess your specific condition, your overall health and, in particular, you spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examination or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan to beginning care. If during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you.

Our practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our method is specific adjusting to correct vertebral subluxations. Because the condition of every patient is different, treatments are made specifically to optimally treat the patient and may incorporate procedures such as, but not limited to exercise, traction, ultrasound, hot/cold therapy, electric stimulation therapy, manual therapy, laser, vibration, hydromassage therapy, and spinal decompression.

**Treatment Risk:** Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. Fractures are rare occurences and generally result from some underlying weakness of the bone. One of the rarest complications associated with chiropractic care, may be a vertebral artery injury that could lead to stroke, occurring at a rate between *one instance per one million* to *one instance per five million* cervical spine (neck) adjustments.

**Alternative Treatment Options:** There are various choices for health treatment, all of which carry different risks and benefits. They include medication which contain serious side effects, bed rest which alone is not likely to reverse pathology, and surgery which carries the risk of an unsuccessful outcome, permanent complications, and reactions to medications.

**Non-Treatment Risk:** Remaining untreated may allow for the formation of adhesions, reduced mobility, increase of pain and possible nerve damage. Postponing treatment may make the condition more difficult to treat, less effective to treatment, and may progress the complication of the condition.

I understand and accept that there are risks associated with chiropractic care and give consent to the examinations that the chiropractor deems necessary and to the chiropractic care including spinal adjustments as reported following assessment. I intend this consent to apply to all my present and future chiropractic care by Adam Tilson, D.C. and/or other licensed doctors of chiropractic and/or clinical personnel who may be employed or engaged in the practice of Tilson Chiropractic FamilyCare.

_____ _____

(Signature) (Date)

# Agreements and Authorization

**Consent to Health Care Services/Release of Health Care Information**

You, (the undersigned Patient, or undersigned person responsible for consenting on Patient's behalf) hereby request and consent to Patient health care services from Tilson Chiropractic Familycare. The Patient health care services will be provided by licensed, treating chiropractors. Health care services will also be provided by non-chiropractic health care professionals employed, under contract, or otherwise retained by Tilson Chiropractic Familycare.

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**Payment Guarantee**

In consideration of the services provided by Tilson Chiropractic Familycare., Provider to Patient, you agree to; 1.) Guarantee payment of all charges incurred by Patient in connection with such services ("Patient Charges"); 2.) irrevocably assign and transfer to Tilson Chiropractic Familycare, all right, title and interest to medical reimbursement benefits to which Patient is entitled for the purpose of payment of Patient Charges; and 3.) authorize payment of such benefits directly to Tilson Chiropractic Familycare 4.) take full responsibility of the payment of any and all Patient Charges to the extent that these charges are not satisfied by the assigned benefits 5.) take responsibility for the cost of legal fees incurred by Tilson Chiropractic Familycare for efforts to collect any delinquent balances of aforementioned unpaid Patient Charges. If you have insurance, insurance companies will only pay what is covered in each individual's insurance policy. If your insurance policy does not cover services rendered from this office, then you are responsible for the non-covered services at the time they were rendered. If you have aHealth Savings Account (HSA), Flex Spending Account (FSA) or a Health Reimbursement Arrangement (HRA), you must notify the practice so we may make appropriate accommodations for the plans. Tilson Chiropractic Familycare does not directly bill to any HSA, FSA, or HRA plans; however, depending on your plan arrangements, automatic withdrawals may occur when we submit to your primary insurance. Any refunds or reimbursements to HSA, FSA or HRA plans cannot exceed your "out of pocket" contribution towards any treatment. (Excludes introductory screening offer if applicable, all services will be discussed prior to being provided)

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**Medicare**

You certify that any information given by you as the Patient or Patient Representative in applying for payment under Title XVIII (18) of the Social Security Act is correct. You authorize any holder of medical or other information about Patient to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medical claim. You authorize payment or authorize benefits to Tilson Chiropractic Familycare on

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**Consent to Release of Information**

Here at Tilson Chiropractic Familycare we respect your privacy, we do not sell or release your information to third parties. There will be cases along the course of your care where information will need to be released in certain circumstances. You authorize Tilson Chiropractic Familycare to release to employer groups, government agencies (Medicare, Medicaid, Champus, State or Federal governments etc.), insurance companies, or other third-party payers and their agents, and its collection representative and attorneys, the following "Patient Information": medical history, diagnoses, and procedures performed, course of treatment, plan of care, prognosis, supplies and/or such other information that may be requested for the purpose of determining eligibility and availability of Patient's benefits, obtaining authorization/payment for the Patient's health care services or billing and collection of amounts due to Tilson Chiropractic Familycare for services rendered. In the case of Patient Information released for purposes of payment of Patient Charges, this authorization shall be valid only for the period of time necessary to process payment claims. You agree to pay any Patient Charges that are denied or are ineligible for medical reimbursement benefits as a result of your refusal or revocation of consent to disclose Patient Information.

You further authorize any individual health care professionals, including treating physician(s), to provide Tilson Chiropractic Familycare or its designee with Patient Information for quality assurance and/or risk management purposes. Finally, in the event that the Patient's employer, or an insurance company representing such employer,

requests Patient Information relating to healthcare services provided for worker's compensation injuries, it is understood and agreed that Tilson Chiropractic Familycare is required, under state law, to release copies of such information to such employer or insurance company without the authorization of Patient or Patient's representative. Again here at Tilson Chiropractic Familycare we strive to provide you with the best care possible and in order to do that this consent is needed.

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**Responsibility for Personal Property**

You accept sole responsibility for all Patient property, except for property expressly accepted by Tilson Chiropractic Familycare for safekeeping under its sole care and custody.

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**Consent to Communication**

You authorize Tilson Chiropractic Familycare to contact you using the communication information you have provided to us such as your phone numbers, mailing address, and email address for appointment reminders, follow up calls, questions pertaining to your treatment, information on health, chiropractic event promotions, and newsletters. You may request non-contact, unsubscription, or frequency changes in writing/email or through our website at anytime. Your contact information will be protected by Tilson Chiropractic Familycare and will not be released or sold to companies without your written consent.

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**No revisions or changes to this form by you will be accepted by Tilson Chiropractic Familycare**

_____ _____

(Signature of Patient/ Parent/Guardian) (Date)

_____ _____

(Signature of Policy Holder) (Date)

_____ _____

(Witness—Office Personnel) (Date)

## Consent to Evaluate and Adjust a Minor Child

I,_____, being the parent of legal guardian of _____ _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____ _____

(Signature) (Date)

## Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above practice and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of late menstrual period: _____ /_____ /_____

_____ _____

(Signature) (Date)

# Patient Privacy Acknowledgement

**For use and/or disclosure of Protected Health Information (PHI)**
**to carry out Treatment, Payment and Healthcare Operations**

I,_____, hereby state that by signing this Consent I acknowledge and agree as follows:

1) The Practice's Privacy Notice has been provided to me prior to my signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice would be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encourage me to read the Privacy Notice carefully prior to my signing this Consent.

2) The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3) This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information.

**I have read and understand the foregoing notice, and all my questions have been answered to my full satisfactions in a way that I can understand.**

_____ _____
(Signature of Patient/ Parent/Guardian) (Date)

_____ _____
(Printed Name of Patient/Parent/Guardian) (Date)

_____ _____
(Witness—Office Personnel) (Date)