Oakland Sports Chiropractic

Informed Consent for Chiropractic Care and Ancillary Services

Oakland Sports Chiropractic is focused on helping patients achieve their optimal health and performance. While this process may involve the use of chiropractic care, exercise prescription, taping and modalities, the primary process for this informed consent is through the use of chiropractic care and its associated therapies and modalities. Dr. Mosure-Judge and the Oakland Sports Chiropractic team are utilizing their skills to help you, the patient, achieve your personal health goals. You, the patient, have a right to know about the processes involved in your care, as well as their associated benefits, risks and alternatives to treatment. We will do our best to inform you of the cost of treatment prior to care, but ultimately it is your responsibility to inquire about the cost of care and treatment options.

Nature of Treatment:

Chiropractic is a form of health care that looks at the joints in the body for vertebral subluxations (misalignments). Chiropractors have a very specific way of looking at how the nervous system is functioning in the body. A vertebral subluxation is a term that chiropractors use to distinguish if there is a slight misposition of the vertebra in the spine or other joints, and it's effect on the nervous system. To correct misalignments chiropractors perform an adjustment. An adjustment is a physical force into the spine to remove the subluxation and restore function to the body. This can be done many ways, including manual force by hand, instruments, or using specific tables and levers. A popping sound may be heard, and is normal. The chiropractor may also use different physical modalities, nutritional recommendations, exercises/rehabilitation, and/or manual therapy to aid in the healing process. Physical modalities may range from the use of ice, heat packs, lasers, or others. These modalities are used to help the body heal and return to function. Manual therapy and massage are physical modalities that involve relaxing the soft tissues of the body, restoring proper circulation, and help the nervous system work with the body. Manual and massage therapy are performed by hand, but can also be done using instruments. Exercise may consist of home exercises, testing, or prescription for specific training workouts. The type of exercises may range from cardiovascular exercise, strength training, stabilizing or neuromuscular reeducation. Exercise testing is a way to analyze a person's fitness using a bike, treadmill, rowing or other machines. The process of exercise testing can vary and includes many tools. Nutritional recommendations may consist of changes to diet or addition of a supplement to help the nervous system function.

Associated Risks and Benefits:

There are risks and benefits associated with all of our services provided here. The benefits of chiropractic care consist of the possibility of improved function, decreased pain, increased range of motion, improved mood, an increased immune system, along with other health improvements. The additional use of manual therapy, physical modalities, nutrition or exercise prescription may be beneficial to your health by increasing blood flow, improve muscle and tissue function, improve cardiovascular function, metabolism, as well as decrease pain or prevent/decrease disease.

The risks of chiropractic could range anywhere from slight muscle soreness, possible rib fracture, or in rare cases, stroke or death. Please be aware that physical modalities, exercise and associated testing, manual/massage therapy and nutrition may cause severe burns, increase in pain and injury, fatigue, dizziness, moodiness, strains, heart attack, stroke, or an allergic reaction which may result in death. You the patient have the right to be aware of these risks and benefits, and to provide the doctor with any information or questions you may have. It is also your responsibility to inform the doctor of any possible contraindications to care, such as a history of heart or clotting disease, or changes to your health, such as a sunburn, falls/trauma, or medications, which may increase the risk of severe reactions.

Alternatives to Care:

Alternatives to care could be seeking medical treatment, pain relief aids in the form of pills, creams or ointments, as well as physical therapy, homeopathy or other type of alternative medicine. Please keep in mind that there are also associated risks and benefits with these treatments and it is your responsibility to obtain any additional information from those providers.

By signing the line below, you the client are consenting that you have been fully informed of your condition, accept any associated risks and benefits of care, and have had any questions concerning your care plan or condition answered. The chiropractor has fully informed you of your options that he or she knows of for care both verbally and written through this form. You are aware that the chiropractor has the right to change his or her decision for care based on your compliance and diagnostic evidence. You will be informed of any changes if or when they occur.

Name: _____ Date: _____

Signature: _____

*Parent/Guardian Signature: _____

*A parent or guardian's signature is needed if the patient is under the age of 18 and/or cannot legally consent on his or her own.

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Agreements and Authorization

Consent to health care services/ Release of health care information/Responsible for Personal Property

You (the undersigned patient, or undersigned person responsible for consenting on patients behalf) hereby request and consent to patient health care services from Oakland Sports Chiropractic. 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 Oakland Sports Chiropractic. I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic health care in an open and/or private treatment area and I give authority for these procedures to be performed. I also give authority for confirmation of my appointments via telephone answering machines or services as well as text and/or email if I have provided you with the pertinent information. Medical, nursing, and other health care personnel who are in training my also participate in the patients care as part of their education.

You accept sole responsibility for all patient property, except for property expressly accepted by Oakland Sports Chiropractic for safekeeping under its sole care and custody.

Initial: _____

Release of Health Care Information/Multiple Provider Practice

I understand that multiple providers work on the same premise of Oakland Sports Chiropractic. These providers may be under contract, employed or renting at our facility and share the same record system, communication system, and staff. I understand they may have access to my personal data, and that they will continue to abide by HIPAA rules and regulations termed by the government and in their contracts. If I am a patient of multiple providers at Oakland Sports Chiropractic's location I am allowing all my providers to discuss my case information verbally and written should they need to collaborate to determine my best clinical outcome.

I also allow the release of my personal information to the following individuals should there be an emergency or to help manage my care:

Name:_____ Contact: _____ Relationship: _____

Name: _____ Contact: _____ Relationship: _____

Initial: _____***N/A***

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 authorized benefits to Oakland Sports Chiropractic on patients' behalf.
*Medicare covers only spinal adjustments, when the doctor feels that they meet Medicare's requirement of medical necessity. All other services that we deliver here in our office are excluded by Medicare because they are ordered or delivered by a chiropractor.

Initial: _____***N/A***

Consent to evaluate and treat a minor/dependant

I,_____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to be treated at Oakland Sports Chiropractic as often as the doctor suggests indicated by verbal or written treatment plan.

I also hereby authorize _____ to schedule appointments and be treated without a parent or guardian present.

Initial: _____***N/A***

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Consent to release of information

Please continue and sign consent to release of information

Here at Oakland Sports Chiropractic 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 Oakland Sports Chiropractic to release to employer groups, healthcare vendors for proper patient/provider communication (email, EHR, reminder call services, etc), government agencies (Medicare, Medicaid, Champus, State or Federal government etc.), insurance companies, or other third party payers and their agents, and its collection representatives 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 patients health care services, or billing and collection of amounts due to Oakland Sports Chiropractic 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 revocation of consent to disclose patient information.

You further authorize any individual health care professional, including treating physician (s), to provide Oakland Sports Chiropractic or its designee with patient information for quality assurance and, or risk management purposes. Finally in the event that the patients employer or an insurance company representing such employer, request patient information relating to healthcare services provided for worker's compensation injuries, it is understood and agreed that Oakland Sports Chiropractic is required, under state law, to release copies of such information to such employer or insurance company without the authorization of patient or patients representative. Again here at Oakland Sports Chiropractic we strive to provide you with the best care possible and in order to do that this consent is needed.

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:

I. The practice's Privacy Notice has been offered, displayed, and/or 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. I understand that the privacy notice is available to me in the future at my request. I understand I have a right to obtain a copy of the privacy notice prior to signing this consent, and the practice has encouraged me to read the privacy notice carefully prior to my signing this consent.

II. The practice reserves the right to change its privacy practices that are described in the privacy notice, in accordance with applicable law

III. The practice "notice of privacy practices" is also provided on request at the main administration desk of this practice. I may obtain a revised Notice of Privacy Practice by calling the office and requesting a revised copy be sent in the mail, or ask for one at the time of my next appointment. I may also request a copy from this office at any time via US Mail.

IV. This notice of privacy practices also describes my rights and duties of this office with respect to my PHI.

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

Printed Name: _____ Date: _____

Signature: _____ Date: _____

Parent/Legal Guardian Signature (if applicable): _____