Grant Family Chiropractic

Remove obstacles * Restore function * Improve performance * Maximize potential

Health Insurance Portability Accountability (HIPAA) Patient Health Information Consent Form

Our Privacy Practices:

In our office, all health information is considered confidential, and we are careful about how we use it. This notice describes how your health information may be used and disclosed and how you can get access to this information. Please read about your health information and let us know if you have any questions.

We may share your health information for the following reasons:

Treat you	Collect payment	Run our office	Do research
Inform you about other services		Include you care classes	Discuss your case w/ family

We may use your health information for the following reasons:

Health & Safety reasons	Court hearings/filings	Reporting to law officials
Reporting victims of abuse	Reporting to Worker's Compensation	

You have the right to the following information:

Request a copy of your health record	Request a list of whom we share your health information with
Ask us to limit the information we share	Request confidential communications
Amend your protected health information	Advise our management if you believe your privacy rights have been violated

These privacy practices are continually in effect throughout your care with Grant Family Chiropractic.
You may rescind this at any time by notifying us in writing.

For further information please contact: Dr. Pamela Grant / Grant Family Chiropractic / 317-219-0354

Consultation & Exam:

To begin today's visit, we will collect some confidential health information and then sit and speak with you. After we learn more about your condition, we will perform some preliminary screening tests.

If we believe that we may be able to help you, we will recommend a complete examination so we can thoroughly evaluate your condition.

We will always inform you of associated fees before we perform any procedure or service.

Report of Findings:

Patients who are examined will receive a report of findings from the recorded history, consultation, and examination.

If we believe we can help, we will accept your case at this time. If we believe that you will not respond to our care, we will not accept your case and may refer you to another provider.

Treatment Plan:

If we accept your case, we may recommend treatment options based on your unique needs and then an individualized treatment plan me be created to address your short &/or long-term goals.

As you advance through treatment, periodic progress evaluations will measure and compare your improvement.

I understand and agree to the following:

- The privacy practices have been satisfactorily explained to me and I have received a copy of the Notice of Privacy Practices or had an opportunity to receive a copy
- I understand the purpose of today's visit
- GFC may use my confidential health information in the manner previously described

_____
Patient or Guardian Signature

_____
Date

Please Turn Over →

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OFFICE POLICIES & PROCEDURES

1. Symptoms: Regardless of the reason you came to our office, it is important to understand the difference between symptoms and their cause. As your spine is corrected you will have good days and bad days. Don't get caught up in this roller coaster; it is normal. This takes time and is a lifelong process. Stay focused on this outcome so you are pleased with your results and enjoy the journey.

2. Appointments: A certain number of adjustments is necessary to get the best results from your care and create wellness in your life. While we can't predict the exact number of adjustments you will need, we do know that consistency creates the best results. Therefore, it is necessary that you keep your appointments. If you need to change an appointment, please call-in advance to reschedule it within 24 hours **so you stay on target for wellness**.

3. Daily Visit Procedure: Each time you arrive for your adjustment, please sign in on the iPad at the front desk and have a seat in the reception area. Our Chiropractic Assistants will direct you to an adjusting / therapy room when it is time to start your visit. Should you feel the need for a private adjustment or consultation, inform our staff and we will gladly accommodate you.

4. Examinations: During your initial phase of care, you will receive several Dynamic Examinations to monitor your level of spinal correction. Plan on spending approximately 15-20 minutes on these days. There is an additional fee for this visit unless you are on a Corrective Adjusting Plan that is inclusive in your financial arrangement. Following your Dynamic Examination, the doctor will give you your adjustment and set you up for a time to go over the results.

5. Exercise: Many people try to correct their spine with exercise. Research shows that people who exercise on an injured spine, that has healed improperly, will tend to experience more rapid deterioration of their spinal bones, discs, and nerves. **However, when you exercise in conjunction with your Chiropractic adjustments, you will find that your spine will improve more quickly, and your athletic performance will be dramatically enhanced.** We recommend that you do some type of aerobic exercise, such as walking, at least once a day.

6. Nutrition: Good nutrition is important to maximize your health and healing capacities. A diet filled with fresh fruits and vegetables will fulfill your nutritional needs daily.

7. Results: We are very results-oriented, however many factors that we have no control over may affect how quickly you respond to your care. These include your age, occupation, how long you have had your vertebral subluxations, and how many subluxations are present in your spine. Regardless of these circumstances, your body has an incredible ability to heal itself. The recommendations we make will consider these factors along with the current condition of your spine. We will do all we can to get you to Wellness Care as quickly as possible.

8. Insurance: As insurance is a contract between you and your insurance company, final payment will be your responsibility. We will pursue insurance collection first and then we will bill you for any remaining balance.

9. Cancellations: If you know you cannot make your appointment, please call our office to cancel / reschedule at least 24 hours in advance. We usually have a waiting list for appointments and when you do not show up for a scheduled appointment, it creates an unused appointment slot that could have been used for another patient.

Your **1st No Show** will result in a $25 no-show fee. This will be charged to your ledger and paid by your credit card on file with our office.

Your **2nd No-Show** occurrence will result in a $50 no-show fee. This will be charged to your ledger and paid by your credit card on file with our office. Each time thereafter, there will be a $50 charge to your account that will be paid by your credit card on file with our office.

10. New Patients If you fail to show for your first appointment, you will be charged a No-Show fee of $50. This fee must be paid before another new patient appointment can be scheduled.

11. Credit Card Policy: Upon starting care we require a credit card on file**.** Any unpaid balances will be billed to the credit card on file. Should you discontinue care for any reason, with a balance, we will bill you one time (1x) before using the credit card on file to pay down any remaining balance.

12. Refund: Should you commit to a care plan at a discounted rate and decide to discontinue your care plan prior to the completion of your recommended schedule, all services that have been performed at that discount will be re-calculated at our retail price of $60.00/visit as well as all other services that have been performed during that time. You will not be billed for any care that has not been performed.

13. Therapies: If therapies are performed and your insurance does not cover them, they will be billed to you at an additional cash-rate cost of: 1-2 therapies = $15, 3 therapies = $20, $5/additional therapy beyond 3 therapies. Cold laser therapy is $20 per 20-minute session. Medical taping is $10 per region.

Patient Signature: _____ Date: _____

AUTHORIZATION TO USE & DISCLOSE PROTECTED HEALTH INFORMATION

Your authorization is requested for the purpose of delivering your care in an open adjusting or open-door adjusting environment as described in the office's privacy notice.

During your care either of these environments, routine details of your condition and care may be disclosed to other patients in the approximate vicinity of where your care is being delivered. We cannot assure that any of the details of your care will be addressed and considered confidential by other patients.

We request your authorization in this regard to assure that you are fully informed and in agreement with the method and circumstances in which we deliver chiropractic care. Your care will not be conditioned on your agreement to this authorization. You have the right not to sign this authorization and you also have the right to revoke this authorization later if that is what you wish. If you wish to revoke this authorization at some time in the future, please advise us accordingly in writing.

If you agree to this authorization, a copy will be maintained at this office and a copy will be provided to you.

Thank you for your cooperation and understanding.

Printed Name Signature Date

If you are a minor, or if you are being represented by another party

Personal Representative (Print) Signature Date

Description of the authority to act on behalf of the patient

INFORMED CONSENT FOR CHIROPRACTIC CARE

Chiropractic is a science, philosophy and art which concerns itself with the relationship between the spinal structure and the health of the nervous system. As chiropractors, we understand that health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes an unhealthy change to the nerve function and interference with the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

If at the beginning or during care we encounter a non-chiropractic issue or unusual findings, we will advise you of those findings and recommend some further testing or refer you out to another health care provider.

Chiropractic care has been proven to be very safe and effective. It is not unusual however, to be sore after your first few corrective adjustments.

Although rare, it is possible to suffer from other side effects; ex. muscle spasms, stiffness, rib fracture, headache, dizziness and/or stroke. Therefore, we like to advise all our patients of the following:

In recent years, there have been rare incidents of injury to the vertebral artery during care by medical doctors, physiotherapists and chiropractors. The risk of stroke after cervical adjustments is 0.00025%.

To put this in perspective, the risk of stroke in the general population is 0.00057% and the risk of death from taking aspirin and other anti-inflammatory drugs is 0.04%.

Tests will be performed on you to minimize this risk and an appropriate adjusting technique will be applied, if necessary.

I understand and I am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the procedure which the doctor feels at the time, based upon the facts known, is in my best interest.

Chiropractic care is **one of the safest and most effective** forms of care. If you have any questions, please ask Dr. Pamela J. Grant.

I intend this consent form to cover the entire course of treatment for my present condition and for any future condition (s) for which I seek treatment.

I have read the above and I consent to care at Grant Family Chiropractic, LLC.

Signature:_____ Date:_____

Signature of Parent/Guardian:_____ Date:_____

(if patient is under the age of 18)

Information released from: The National Center for Health Statistics USA, 1993 and A Risk Assessment for Cervical Manipulation vs. Non-Steroidal Anti-Inflammatory Drugs for the Treatment of Neck Pain, JMPT, Oct. 1995.

STATEMENT OF NON-PREGNANCY AND X-RAY CONSENT

X-rays are one way of looking inside a person's body. Chiropractors use x-ray analysis as one of the tools that help tell if your body is properly balanced and if your vertebrae and other skeletal structures are in proper alignment. This helps us determine your structural integrity.

Long-standing nerve stress (subluxations) may cause a condition of inflammation of the bone and related structures and premature ageing called spinal degeneration. An x-ray can tell us if you have this condition.

X-rays are a form of electromagnetic radiation and may have adverse effects on body tissue, especially rapidly dividing cells. For that reason, it is best to avoid x-rays when pregnant. Please sign below so we may proceed appropriately.

FEMALES: I, _____, in signing this form, state to the best of my knowledge, ***there is no pregnancy, confirmed or suspected at this time.***

EVERYONE: I, _____, ***consent to x-rays*** as Dr. Grant and Grant Family Chiropractic deem necessary.

Patient Signature:_____ Date:_____

INSURANCE FORMS/PAYMENT

If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request of more information regarding your care, please bring it in as soon as possible. It is very important that we keep your file as up to date as possible. Occasionally, either by mistake, or due to provisions in your policy, the check issued by the insurance company for payment of services rendered in our office, may come to you instead of our office. If you should receive any unexpected check in the mail, please contact us to see if it does represent payment of your bill here.

I have read and understand the payment policy of Grant Family Chiropractic. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Grant Family Chiropractic and my insurance company. I request that Grant Family Chiropractic prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctor at Grant Family Chiropractic that fees will be due and payable immediately.

_____ _____

Patient's signature (or guardian if patient is a minor) Date

AUTHORIZATION TO RELEASE RECORDS

I, _____, hereby request and authorize you, your employees and agents to furnish to the person(s) listed below or anyone designated in writing by him/her/them, all records, information, reports, including x-rays and photo-static copies, abstracts or excerpts of all records and any other information he/she/they may request relating to any examination, treatment or opinion concerning any condition that I may have had in the past or now have. I understand that by Indiana Law, the physical records (x-rays, files, forms, etc.) pertaining to my case is the property of Grant Family Chiropractic. I further understand that I am entitled to all the information contained in those files.

I hereby release Grant Family Chiropractic and its entire staff of any consequences relating to the release of my records. This document shall serve as legal proof of possession of these records by the person whose signature appears below.

_____ _____

Signature Date