Informed Consent for Chiropractic Treatment

Patient Name:___________________________________

To the patient:

Please read this entire document prior to signing it, it is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment:

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you; I may use my hands or a mechanical instrument 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 a sense of movement.

Analysis/Examination/Treatment:

As part of the analysis, examination, and treatment you are consenting to all the following possible procedures.

Please initial next to the procedures below:

Spinal manipulative therapy ____ Orthopedic testing_______

Palpation_____ Range of motion testing_______

Postural analysis______ Cold/hot therapy______

Muscle strength testing_____ Vital signs_____

Myofascial release_____ Basic neurological testing______

Cold laser therapy_____ Percussion therapy____

Other (please explain)____

The material risks inherent in chiropractic adjustment:

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include, but are not limited to: fracture, disc injuries, dislocations, muscle strain, cervical myslopathy, costrovertebral stains, and separations, and bruises. 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. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risk occurring:

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during taking your history and during examination, stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one on one million and one in five million cervical adjustments. The other complications are generally described as rare.

The availability and nature of other treatment options,

Other treatment options for your condition may include:

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

If you choose to use the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risk and dangers attendant to remaining untreated:

Remaining untreated may allow the formation of adhesions and reduce mobility which may set 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.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPPROPRIATE 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 any questions or concerns with Dr. Stevanie Bahnerth and had them answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Date: ____________________	Date: ____________________
____________________	____________________
Patient's Name	Doctor's Name
____________________	____________________
Signature	Signature

____

Signature of Parent or Guardian (if a minor)

PATIENT CONSENT FORM

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **Healthy Images** to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). (The Notice of Privacy Practices provided by **Healthy Images** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Healthy Images** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Healthy Images**, **29455 N. Cave Creek Rd. Ste 124, Cave Creek, Arizona 85331.**

With this consent, **Healthy Images** may call my home or alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **Healthy Images** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, **Healthy Images** may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Healthy Images** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **Healthy Images** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Healthy Images** may decline to provide treatment to me.

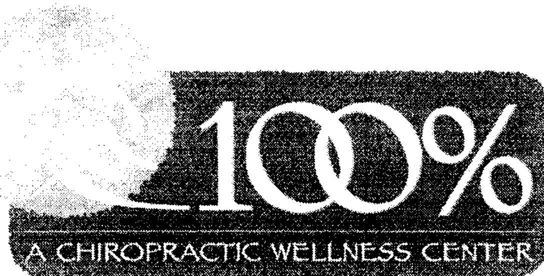
Signed By: ______________________________ ______________ ____________________

Signature of Patient or Legal Guardian | Date | Relationship to Patient

______________________________ ________________________________

Print Patients Name | Print Name of Legal Guardian, if applicable

Patient/Guardian must be provided with a signed copy of this authorization form.



Pediatric History Form

Date_______________ Referred By_______________

Patient Name_______________ Phone Number_______________

Address_______________

City_______________ State_______ Zip_______________

Birth Date_________ Sex_______ Weight_________ Height_____ _______________

Names of Parents/Guardians_______________

Purpose for contacting us?_______________

Other doctors seen for this condition_______________

Treatment_______________

Check any of the following that pertains to your child:

- ☐ Ear Infections
- ☐ Asthma
- ☐ Allergies
- ☐ Colic
- ☐ Scoliosis
- ☐ Digestive Problems
- ☐ Bed Wetting
- ☐ Seizures
- ☐ Recurring Fevers
- ☐ Constipation
- ☐ ADHD
- ☐ Auto Accident
- ☐ A Fall
- ☐ Traumatic Birth
- ☐ Diarrhea
- ☐ Temper Tantrums
- ☐ Headaches
- ☐ Chronic Colds
- ☐ Adverse vaccination reaction
- ☐ Other_______________

Family History_______________

____

Name of Pediatrician_______________ Date of last visit_______________

Reason_______________ Treatment_______________

Number of doses of antibiotics your child has taken:

1) In last 6 months:_______________
2) Total during his/her life:_______________

Number of doses of other prescription medications your child has taken:

1) During last 6 months:_______________
2) Total during his/her life:_______________

Vaccination history:_______________

Feeding History:

☐ Breast-fed If yes, how long?_______________ ☐ FormulaIf yes, how long?_______________

Introduced solids at _______ months. Cow's milk at _______ months.

Prenatal History:

☐Complications during pregnancy? Explain_______________

☐ Ultrasounds during pregnancy? How many?_______________

☐ Medications during pregnancy/delivery? List them_______________

☐ Cigarette/alcohol use during pregnancy? Frequency__________________

Location of Birth ☐ Hospital ☐ Home ☐ Other__________________

Birth intervention ☐ Forceps ☐ Vacuum Extraction ☐ C-section

Delivery complications? ☐ No ☐ Yes__________________

Birth Weight__________ Birth Length__________ APGAR Scores__________

Childhood Diseases:

☐ Chicken Pox Age:______ ☐ Rubeola Age:______ ☐ Whooping Cough Age:______

☐ Rubella Age:______ ☐ Mumps Age:______ ☐ Other__________________

Developmental History:

At what age was your child able to:

Respond to sound __________ Crawl __________

Respond to visual stimuli __________ Stand Alone __________

Hold head up __________ Walk Alone __________

Sit __________

Has your child ever been involved in a car accident? ☐ No ☐ Yes (List)__________________

Has your child ever fallen? ☐ No ☐ Yes (List)__________________

Prior surgery? ☐ No ☐ Yes (List)__________________

I hereby authorize 100% to administer care to my son/daughter. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signed__________________________________ Date__________________

Relationship to Patient__________________________