North Brunswick Chiropractic and Acupuncture
INFORMED CONSENT

CHIROPRACTIC

It is important to acknowledge the difference between the healthcare specialties of chiropractic, osteopathy, and medicine. Chiropractic seeks to restore health through natural mean without the use of drugs or surgery. This gives the body maximum opportunity to utilize its innate recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic healthcare services.

ANALYSIS

A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Complex (VSC). When such VSC are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its innate recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends on the inherent recuperative powers of your body.

DIAGNOSIS

Although doctors of chiropractic are experts in chiropractic diagnosis, the VSC, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her condition. Your doctor of chiropractic may express an opinion as to whether or not you take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment or health care, if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

RESULTS

The purpose of chiropractic services is to promote natural health though the reduction of the VSC. Since there are so many variables, it is difficult to predict the time schedule or efficiency of the chiropractic procedures. Sometimes the response is phenomenal. In most cases, there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions which do not respond to chiropractic care, may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

TO THE PATIENT

Please discuss any questions or problems with the doctor BEFORE signing this statement of policy.

I have read and understand the foregoing.

OFFICE POLICIES

If I am accepted as a patient at North Brunswick Chiropractic and Acupuncture, I agree to pay for all services including services not covered by my insurance company. If I suspend (or terminate) my treatment without the doctor's permission, it will be understood that I have reached maximum healing for my condition. I then agree to be fully responsible for y condition and future care. I understand that no medical records or x-rays will be released from this office if I owe any money on my account.

CONSENT TO TREAT

I also understand that no cures are promised (or implied) and any risks regarding this care at this office will be explained to me upon my request. I now authorize Dr. Chris Rizzo or Dr. Pamela Betz to proceed with any necessary treatment. I have read North Brunswick Chiropractic and Acupuncture's office policies and consent to treat information, and I agree with them by signing below.

Patient Name Printed _____ Date_____

Patient Signature _____

North Brunswick Chiropractic and Acupuncture
AUTHORIZATION FOR THE USE OF PROTECTED HEALTH INFORMATION

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operation purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organization. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms.

_____ _____

Patient Print Name Provider

_____ _____

Patient or Guardian Signature Date

_____

Date

North Brunswick Chiropractic and Acupuncture
AUTHORIZATION REMINDERS & HEALTHCARE INFO AUTHORIZATION

(Required by the Federal Government effective 4/14/2003)

Our office may need to use your name, address, phone number and clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information pertaining to your care at our office. If this contact is made by phone and you are not at home, a message will be left on your answering machine or with whoever answers. By signing this form, you authorize us to contact you via message.

You may restrict to whom your information is released. You may revoke your authorization to us at any time in writing. Upon receipt of written revocation, no further messages would be left regarding your health information. Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone with access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse this authorization. If you choose to do so, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or request a copy of the information that we use to contact you in order to provide appointment reminders, information about treatment or other health related information at any time. (Article 164.524)

This notification is effective as of the date indicated below and will expire seven years after the date on which you last receive services from us. A copy of this authorization is available upon request.

_____ _____

Patient Print Name Date

_____ _____

Patient or Guardian Signature Provider