

Consent for Chiropractic Treatment and Acknowledgement of Receipt Information

To the patient: Every type of healthcare is associated with some risk of a problem. Healthcare providers, including chiropractors, are required by law, to tell you the nature of your condition, the general nature of the treatment, the risks involved, and the reasonable therapeutic alternatives.

In keeping with the Texas law of informed consent, you are being asked to sign a confirmation that we have discussed all of these matters. We have already discussed with you the common problems and risks. Please read this form carefully then ask about anything you do not understand, and we will be pleased to explain it.

In general, chiropractic treatment includes examination, taking x-rays, manipulations and or adjustments, and application of physical therapy modalities. Although their occurrence is extremely remote, some risks are known to be associated with these procedures. These include:

- 1.) Stroke: Stroke is the most serious problem associated with spinal manipulation. The results can be temporary or permanent dysfunction of the brain with a very rare complication of death (1 in 20 million). Spinal manipulations have been associated with strokes that arise from the vertebral artery (located in the neck vertebrae). This problem occurs so rarely that there is no conclusive data to quantify probability.
- 2.) Disk Herniations: Disk herniations create pressure on the spinal nerve or spinal cord. They are frequently treated successfully by chiropractors. Rarely treatment may aggravate the problem, resulting in increased low back pain, radicular pain, and numbness of a transient nature. Residuals may last for a few days but seldom for longer periods of time.
- 3.) Soft Tissue Injury: Soft tissue primarily refers to muscles and ligaments. Muscles move bone and ligament's limit to joint movement. Rarely, treatment may injure some muscle or ligament fibers. The result is temporary increase in pain. Necessary treatments for resolution, but there are no long-term affects for the patient.
- 4.) Rib Fractures: The ribs are found only in the thoracic spine or middle back. Rarely, a manipulation will fracture a rib bone. This occurs only on patients who have weakened bones from such things as osteoporosis. Osteoporosis can be noted on x-rays. We adjust all patients carefully, especially those who have indications of osteoporosis on their x-rays.

For Medicare and/or Geriatric patients there are contraindications to a Chiropractic dynamic thrust which is a therapeutic force used for manipulation of the Vertebral Subluxation Complex. A relative contraindication is a condition that adds significant risk of injury to the patient from dynamic thrust but does not rule out use of dynamic thrust. The following are relative contraindications to dynamic thrust:

Articular hypermobility and circumstances where the stability of the joint is uncertain, severe demineralization of bone, benign bone tumors of the spine, bleeding disorders and anticoagulant therapy, and radiculopathy with progressive neurological signs. Please advise Dr. Blum of any of these conditions you might have. Dr. Blum has a low-force adjuster which will not cause any health risks related to these listed contraindications.

-----CONSENT-----

I hereby authorize and direct Dr. James R. Blum, together with associates and assistants of his choice, to provide chiropractic treatment including examination/diagnostics, spinal manipulation/adjustment, various modes of physical therapy, x-rays and any additional procedures or services that may be deemed necessary or reasonable. This treatment has been explained to me, and alternative methods of treatment (if any) have also been addressed. I have read and understand all information set forth in this document, including any attachments. I acknowledge that I have had the opportunity to ask questions about the contemplated procedure and that my questions have been answered to my satisfaction. This authorization for and consent to chiropractic treatment is and shall remain valid until revoked.

Patient's Printed Name

Date

Time

Signature of Patient, Parent, or Guardian

Relationship to Patient _____

Natural Care Chiropractic and Acupuncture

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Legal Duty

We are obligated maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protect health information. This notice takes effect April 14, 2003 and will remain in effect until we replace it.

You may request a copy of our notes at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us at Dr. James R. Blum, Inc. 3025 E. Renner Road, Suite 120, Richardson, TX 75082. Telephone: 972-309-2041.

Uses and Disclosures of Medical Information

We use and disclose medical information about you for treatment, payment, and health care operations. This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to facilitate payment by third party for services rendered by us, or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMOs and PPOs, managed care organizations, IPAs, CMS, or other governmental or third party payers, or any of the above entities to perform such functions.

Copies of your medical information may be delivered to a primary care physician who is directly or indirectly responsible for your medical care or the payment thereof.

We may use or disclose your medical information to notify a family member or another person responsible for your care based on our professional judgment and the circumstances. We may use your medical information to contact you or leave a message to provide appointment reminders, birthday cards, holiday related cards, and promotional information. I give permission to treat me in an open room where other patients are also being treated. I am aware that other people in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, I will notify the doctor and the staff for a private room.

We may use or disclose your medical information for purposes involving public health and safety issues and activities, death, certain requests from your employer, governmental personnel and programs, organ donation, judicial and administrative proceedings, law enforcement, abuse, neglect or domestic violence issues and workers' compensation issues.

Individual Rights

This office will not use or disclose any of your medical and financial information for any purpose not stated above without your specific authorization. You may revoke your authorization at any time. You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect, copy and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office. We charge a cost-based fee for copying of records and for postage.

Questions and Complaints

You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. This office will make no retaliation against you because you registered a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

Patient Signature _____ Date _____

Parent/Guardian _____ Date _____

DR. JAMES R. BLUM, D.C., C.C.N., Dipl. Ac.

3025 E. Renner Road, Suite 120
Richardson, TX 75082
Phone: (972) 309-2041
Fax: (972) 231-6392

Assignment of Proceeds and Instruction for Direct Payment to the Doctor

PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

I hereby direct and instruct my attorney or insurance company to pay all sums owed to Holistic Kinesiology Family Chiropractic from the proceeds from any and all personal injury protection coverage, medical payments coverage, major medical policies, third-party liability insurance, uninsured/underinsured motorist coverage, and/or disability benefits. Pay by check made out and mailed directly to:

**DR JAMES R. BLUM
3025 E. RENNER ROAD, SUITE 120
RICHARDSON, TX 75082**

If my current policy prohibits direct payment to the doctor, then I hereby also instruct you to make out the check to me and mail it as follows:

**HOLISTIC KINESIOLOGY WELLNESS CENTER
3025 E. RENNER ROAD, SUITE 120
RICHARDSON, TX 75082**

The professional or medical expense benefits allowable and otherwise payable to me under my current policy as payment toward the total charges for professional services rendered. This is a direct assignment of my rights and my proceeds under this policy and considered irrevocable. This payment will not exceed my indebtedness to the above mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

In the event an insurance check is made out and mailed to me, I will mail it or deliver it directly to Holistic Kinesiology with seven (7) days.

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

SIGNATURE OF POLICY HOLDER

DATE

WITNESS

DATE