Office Policies and Consent to Treat

Patient Name: _____

Consent to Treat

I hereby request and consent to the performance of chiropractic procedures including chiropractic manipulation, physical therapy procedures, diagnostic x-rays, and other supportive therapies on me by the doctors of chiropractic who are, or will be in the future, employed or contracted with Seatac Spine and Wellness, as deemed necessary by the attending doctor of chiropractic. If the patient is a minor child under the age of 18 years or of limited capacity at the date of treatment, I hereby stipulate I am the legal guardian of the patient, and grant my consent for the treatment of the minor as provided for herein. I am informed I may withdraw my consent at any time and refuse treatment.

Sign: _____ Date: _____

Informed Consent

I have had the opportunity to discuss with the doctor of chiropractic and/or with other staff personnel the nature and purpose of chiropractic adjustments and procedures. I understand and am informed that, as with all health care treatments, results are not guaranteed, and there is no promise of a cure. I further understand and an informed that, as is with all health care treatments, in the practice of chiropractic there are risks to treatment which include but are not limited to, muscle spasm, aggravation of/ or a temporary increase in symptoms, no improvement in symptoms, fractures, disc injuries, stroke, dislocations, and ligament sprains. I do not expect the doctor to be able to anticipate all risks and complications, and wish the doctor of chiropractic to exercise judgement during the course of treatment, which the doctor feels at the time, based on facts known at the time, to be in my best interests. The doctor and his staff will not be responsible for any health conditions or diagnoses that are pre-existing, given by another healthcare practitioner, or not related to the spinal structural conditions diagnosed at this office.

I further understand and am informed that there are other option available to me for my treatment other than chiropractic treatment. These options include but are not limited to self-administered over the counter analgesics, rest, medical care, prescription medication, physical therapy, steroid injections, bracing, and possibly surgery. I have been informed I have the right to a second opinion and to secure other treatment options at any time if I so wish.

Sign: _____ Date: _____

Consent to x-ray

I consent to the performance of x-rays deemed necessary by the attending doctor of chiropractic. I acknowledge there are certain risks associated with x-rays. I certify I have no known limitation that would forbid the taking of x-rays.

The office may seek outside interpretation of patient x-rays by a qualified professional not employed by this office. I agree to additional fees incurred for these services and assign benefits to be paid directly to that professional by my third party payor.

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform, if necessary, an x-ray examination. I have been advised that x-rays are hazardous to an unborn child.

Sign: _____ Date: _____

Office Policies and Consent to Treat

Financial Obligations

I accept full financial responsibility for services rendered by this practice. Payment in full is required at the time of service unless other arrangements have been made and agreed to in advance of treatment. I accept full responsibility for fees incurred, including but not limited to legal fees, collection agency fees, or any other expenses incurred in the collection of past due accounts. If it is deemed necessary to file a lien for medical bills with the King County Recorder I accept full responsibility for all fees incurred to file the lien and to file the satisfaction of lien.

I hereby assign benefits to be paid directly to Seatac Spine and Wellness by all of my third party payors. Assignment is irrevocable. Failure to fulfill this obligation will be considered a breach of contract between me and this office.

I authorize this office to release any information required by a third party payor necessary for reimbursement of charges incurred.

Sign: _____ Date: _____

Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Heath Information Portability and Accountability Act (HIPPA) is available at: http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/HIPAAGenInfo/TheHIPAALawandRelated-Information.html

1. The patient understand and agree to allow this office to use their PHI for the purpose of treatment, payment, healthcare operations and coordination of care with other healthcare professionals. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.

2. The patient has the right to examine and obtain a copy of their health records at any time and request corrections. The patient may request to know what disclosures have been made, and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions.

3. The patients written consent shall remain in effect for as long as the patient recieves care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.

4. This office is committed to protecting your PHI and meeting its HIPPA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.

5. Patients have the right to file a formal complaint with our privacy official about any suspected violations.

6. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Sign: _____ Date: _____

Name Printed:_____

____The patient is a minor of of limited capacity requiring guardianship for treatment, therefore as guardian of the patient I give consent by my signature to the consent and policies above.