CAROLINA
Active Health
CHIROPRACTIC

Informed Consent

Consent for Examination and Treatment:

I (we) hereby consent to the performance of examination and treatment on me or on _____, by the licensed doctors of chiropractic, medical doctors, exercise specialist, massage therapist, physical therapist, and/or any other person who may be employed by or engaged in practice in this clinic. This also includes any modality utilized in my treatment including but not limited to electrical stimulation, heat, Normatec, laser therapy, blood occlusion, IASTM, stretching, and taping. Laser therapy is a safe, non-invasive, FDA cleared modality for the treatment of pain and the temporary increase of microcirculation. Increased microcirculation can provide relief for many acute and chronic conditions. Laser therapy utilizes visible and invisible laser radiation, therefore, appropriate eye protection is required at all times during treatment.

I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgements based upon facts and information known to the doctor. The doctor uses this judgement to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgement. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests. I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which rarely includes, but not limited to fractures, disc injuries, strokes, sprains/ strains and I am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

Additionally, as part of treatment I will participate in a provided therapeutic exercise program with goals to:

- Strengthen your muscles
- Increase your cardiovascular endurance, range of motion, and flexibility
- Decrease overall pain
- Return you to full duty, non – restricted work status and lifestyle

The process of strengthening and conditioning are a form of “controlled strain” and there is a risk of aggravation of injury. It is therefore imperative that you communicate to the physician, any aggravation or injury that you may observe during the rehabilitation process. *For example the best exercise for you, if performed too early in your condition, may be your worst enemy if performed too soon.* Communication with your provider will help put into perspective problems that may occur. Failure to discuss problems may only foster additional problems down the road.

Success of any rehabilitation process lies in the combined efforts of you and your provider. The “team” approach has the best chance of attaining your goals, so please ask as many questions as necessary for you to gain the maximum benefit for your rehabilitation program. Your participation in the rehabilitation program is voluntary. You can stop at any point in the program. Should you stop your program, we are obligated to notify your doctor, insurance company, attorney, and DVR manager if applicable.

I understand and consent to treatment_____ (initial)

By signing below, I agree and intend this consent to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: Are you currently pregnant? Yes or No If currently pregnant-how many weeks? _____

If not pregnant, Date of last menstrual period _____

Patient name: (Print) _____ Date of Birth: _____

Signature: _____ Date: _____

Relationship of authority if not signed by the patient: _____

Witness name: _____

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Insurance and Financial Office Policies

At *Carolina Active Health Chiropractic Inc*. we file most insurance as a courtesy to our patients. Our fees are considered customary and reasonable by most companies and therefore are covered up to the maximum allowance determined by individual plan or carrier. However, not all insurance policies cover chiropractic care. Additionally, some soft tissue treatment techniques such as Active Release Techniques (ART), Instrument Assisted Soft Tissue Mobilization (IASTM), and cupping are unfortunately not covered by insurance and therefore there is an additional $22 cash charge to the patient.

All patient financial responsibilities such as, co-payments, co-insurance, and deductible amounts are expected at the time of service, unless prior arrangements with *Carolina Active Health Chiropractic Inc.* are in place.

Carolina Active Health Chiropractic Inc. utilizes *Patient Options DMCO*, which is a discount medical plan that provides our patients and their immediate family with access to affordable chiropractic care. There is no additional cost to the patient to participate in this plan.

Patients are responsible for paying all fees associated to their treatment at the time of service or by means of a pre-arranged authorized payment plan. We charge an administrative processing fee for processing all extended payment plans. This fee is taken at the time of payment processing. All patient account balances are never to exceed $100.00 due, at any time or you may be subject to discharge from *Carolina Active Health Chiropractic Inc*.

All patients are considered cash pay until ALL signed insurance verification forms are verified and registered. The staff of *Carolina Active Health Chiropractic Inc.* will provide and discuss with you an "Estimated Payment Option Form" as this process is completed. It is a policy of *Carolina Active Health Chiropractic Inc.*, to collect a $79.00 new patient fee as a down payment for services rendered. If insurance eligibility and processing deems a lesser patient responsibility the overpayment amount is credited or refunded directly to your account. If insurance eligibility deems a higher patient responsibility you will be billed directly for the difference.

It is the patient's responsibility to ensure prompt payment (within 90 days from date of service) is made on your behalf from your insurance company to *Carolina Active Health Chiropractic Inc*. ALL outstanding balances over 90 days will become patient responsibility and you are financially responsible for the debt(s), to be paid in full immediately upon receipt.

Upon completion of your prescribed care plan, and/ or completion of insurance visits you will no longer be eligible for insurance assignment of benefits at *Carolina Active Health Chiropractic Inc*. All charges for services and supplies prescribed/rendered at this point, will be due in full, at the time of treatment.

If you elect to discontinue care at *Carolina Active Health Chiropractic Inc.* for any reason other than completion of your prescribed care plan and/or physician discharge, ALL existing balances are due immediately and payable in full by you, regardless of any claim submitted on your behalf.

Cancellation Policy:

Please allow 24 hours' notice if you need to cancel an appointment.
First occurrence - excused
Second occurrence - $30 fee
Third occurrence - $50 fee

Patient name: (Print) _____ Date of Birth: _____

Signature: _____ Date: _____

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Authorization of Private Health Information

Privacy Practices Acknowledgement

Authorization to discuss PHI (Private Health Information)

I (print name) _____ authorize *Carolina Active Health Chiropractic Inc.*, to use or disclose the specific information described below, only for the purpose and parties also described below.

Description of Specific Information to be discussed:

○ Appointment Dates/ Times ○ Diagnosis ○ X- Ray / Lab Results ○ Medications ○ Care Plan

○ Summary of Medical Record ○ Other as specified:

Name of Individual:	Relationship:	Contact Number:

As part of our holistic approach, Carolina Active Health would like to communicate and/or share our clinical findings, treatment plans and therapeutic outcomes with your Primary Care Doctor. If you would like to consent to this process, please complete the following information:

_____ _____

Name of Primary Care Dr and/or Practice Name Phone Number

_____

Address

This authorization shall remain in effect from the date signed below and until _____ or 365 days have lapsed.

By signing below you authorize and understand this form is as described;

- This form is legally binding.
- You may inspect or copy the protected health information to be used or disclosed.
- You may revoke, add, or change, at any time, in writing this authorization by contacting *Carolina Active Health Chiropractic Inc.*, office at 864-881-2242.
- This authorization is giving *Carolina Active Health Chiropractic Inc*., the right to disclose and or discuss my medical information as specified with the **individuals listed above.**
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA.

Patient Acknowledgment of Privacy Practices

I have received and/or reviewed the Notice of Privacy Practice for *Carolina Active Health Chiropractic Inc.*, and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agree to the use of those records when I initially applied for care at this office on my first visit, whenever that may have occurred.
I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement.

Patient name: (Print) _____ Date of Birth: _____

Signature: _____ Date: _____

Relationship of authority if not signed by the patient: _____

Witness name: _____