MountainValley
CHIROPRACTIC

CHIROPRACTIC CARE CONSENT

Thank you for choosing Mountain Valley Chiropractic. We look forward to providing quality healthcare to assist you in achieving your health-related goals. To serve you as efficiently as possible, please answer all the following questions. All information will be held in the strictest of confidence.

Name_____ Age____ DOB_____ M F Marital Status_____ Phone_____
Address_____ City/State_____ Zip_____
Email _____ Occupation_____
Emergency Contact Name_____ Relation_____ Phone_____
Who referred you to us? _____ May we thank him/her? Y N Newsletter Sign-Up? Y N

*I voluntarily consent to be treated with chiropractic care by Joseph Heinecke, DC, of Mountain Valley Chiropractic. Mountain Valley Chiropractic does not accept assignments for Medicare or insurance. This means that Mountain Valley Chiropractic does not see any Medicare-enrolled persons. If you become Medicare enrolled while under the course of care by Mountain Valley Chiropractic, you will be referred to an appropriate Medicare provider. If you have insurance that contributes to your care, Mountain Valley Chiropractic will provide you with the appropriate documentation in the form of a "superbill" to help you with direct reimbursement from your insurance company. Mountain Valley Chiropractic cannot guarantee that your insurance company will reimburse you for services provided and assumes no role in recovering a reimbursement from your insurance company.

*I understand that chiropractic care involves hands-on touching of my body and can include sensitive areas including hips, sacrum, coccyx (tail bone), pubic bone, collar bones and ribs, lymph nodes in the armpits as well as palpation of muscles of both the upper and lower body. Some contact may need to be performed skin-to-skin, but most will be performed over my clothing. If at any time throughout the course of care I feel uncomfortable or do not want contact made with a specific body part, I will let Dr. Heinecke know so that other arrangements for care may be made. **Please initial** _____

*I understand that some diagnostic or examination procedures may be performed if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable. Exams will be performed at the onset of care, annually, or in the instance of an auto accident or serious injury.

*I understand that chiropractic care involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. Hands or an instrument is used to reposition anatomical structures. Potential benefits include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and well-being.

*I understand that no guarantees are given to me concerning the results and effects, and that I am free to stop or refuse treatment at any time. I also understand that there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. The best scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis. Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not.

*I understand that Dr. Heinecke does not diagnose or treat any condition other than Vertebral Subluxation. However, while under the course of care, if he finds or suspects a different or more serious condition requiring treatment, he will inform you as well as recommend that you seek the services of a healthcare provider that specializes in that area of treatment.

*At times you may wish to contact Mountain Valley Chiropractic via email, or vice versa, for communication which may contain protected health information. **Please initial for consent** _____

* Your privacy is important to us. Mountain Valley Chiropractic follows the Health Insurance Portability and Accountability Act (HIPAA) and will never sell any information about you. You have the right to review Mountain Valley Chiropractic's Notice of Privacy Practices and have the right to request that Mountain Valley Chiropractic restrict the use of your protected health information to carry out healthcare operation.

*I understand payment is due at the time of service and I agree to address any financial concerns with Mountain Valley Chiropractic prior to treatment. I understand that Mountain Valley Chiropractic gladly accepts cancellations up to 24 hours in advance without penalty. The first late cancel or missed appointment is without penalty. Subsequent late cancel or missed appointments will be charged 100% of the scheduled treatment. **Please initial** _____

*The above-named patient is a minor. As his/her parent/guardian, I give Dr. Heinecke permission to treat him/her without me being present at said treatment.

Please sign for consent _____ Date_____

I have carefully read, and I understand all the above information. I appreciate that it is not possible to consider every possible complication to care. I am fully aware of what I am signing.

_____ _____

Signature (Patient / Parent / Guardian) **Date**