SANFILIPO CHIROPRACTIC ORTHOPEDICS & REHAB

SanFilipo Chiropractic, Orthopedics & Rehab

PATIENT CONSENT FORM

Patient Name: _____ **Date:** _____

The primary treatment used by doctors of chiropractic is spinal manipulation or adjustments. We will use this procedure in your treatment program.

The nature of the chiropractic manipulation:
We will use our hands to manipulate or loosen and reposition the joints of your spine. Often with this procedure, you will hear a popping noise associated with the loosening and repositioning.

The material risks inherent to chiropractic manipulation:
As with any health care procedure, there are certain complications that may arise from chiropractic manipulation. These complications may include: aggravation of degenerative or injured spinal discs, rib fractures, ligament sprains, muscle strains, nerve injury, or spinal cord compression. Manipulation of the neck has been associated with injury to arteries in the neck leading to or contributing to stroke. Local soreness and/or stiffness are typical in the early phases of treatment.

Probability of those risks occurring:
Fractures are rare occurrences and generally result from underlying bone weakness, which we check for during your history, examination, and x-rays. The exact incidence of stroke is uncertain, but it is generally believed to occur in less than one per million treatments. We employ physical tests that are advocated to screen for this risk, but they are generally accepted as being insensitive. All other complications are also generally described as rare. The incidence of spinal fracture or other serious musculoskeletal injury is estimated at 1:4 million treatments.

The availability and nature of other treatments:
Other treatment options for your condition may include:

- Over the counter medications and rest
- Medical care which may include anti-inflammatory drugs, muscle relaxants, and pain medications
- Surgery

Material risks inherent to your other treatment options:
The common analgesics and anti-inflammatory drugs have been shown to cause damage to the stomach and intestines, and possibly the kidneys. Approximately 1 in 150 patients taking anti-inflammatory drugs for extended time periods require hospitalization for stomach ulceration. There are about 16,500 deaths in the U.S. each year from these complications which is more common than deaths from either Hodgkin's disease or cervical cancer. The risks are similar for both prescription and OTC medications.
Spine surgery may be a consideration for some cases. It, however, is reserved for those cases where extensive conservative treatment has been tried. Spine surgery is associated with a minor complication rate between 9 per 100 and 15 per 100 cases depending on the area of spine involvement. More serious complications of the nervous system may occur in 1 per 400 cases and death has been reported in approximately 1 per 1500 cases

While spinal manipulation is associated with complications in a small number of cases, it has a complication rate of several thousand times less than other typical treatment options.
DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
I have read (___initial) or have had read to me (___initial) the above explanation of chiropractic manipulation or adjustment and related treatment. I have discussed it with the doctor and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Printed Name_____ Witness _____

Signature_____ Signature_____

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PRIME-MD PHQ (2 Question Screen)

Name: _____

Date: _____

During the past month, have you often been bothered by feeling down, depressed or hopeless?

____ Not at all

____ Several days

____ More than half the days

____ Nearly everyday

During the past month, have you often been bothered by little interest or pleasure in doing things?

____ Not at all

____ Several days

____ More than half the days

____ Nearly everyday

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PAYMENT AUTHORIZATION AGREEMENT

It is the policy of this office to submit claims for you to your insurance company. On occasion an insurance company may not authorize treatment for services they feel are not medically necessary. On the event that your insurance company denies payment for services rendered; you will be notified in a timely fashion and subsequently billed.

Please note we will do everything possible to obtain authorization and payment directly from your insurance company.

Please sign below indication that you agree to pau any charges set forth for the health service provided in this office that may not be covered by your insurance company.

The signing of this agreement was done prior to any health service being provided to me.

Patients Signature: _____

Date: _____

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OFFICE FINANCIAL POLICY

Welcome to Our Practice!

We value our relationship with our patients. This financial policy has been established to prevent any misunderstandings.

1. It is your responsibility to keep the practice updated with your most current information regarding insurance, address, phone, etc.

2. Any questions regarding benefit issues or physician participation status should be directed to your insurance provider.

3. The office requires 24 hour prior notice to cancel an appointment. A $15.00 charge may be billed directly to you for missed appointments. Arriving 15 minutes or later past your appointment time will be considered a missed appointment. A new appointment will need to be scheduled and a missed appointment fee may be applied. 3 missed appointments will be considered non-compliance and may result in discharge from care.

4. Payment of your copay is expected at the time of service. If payment is not made at the time of service, a $10.00 administrative/billing fee may be billed directly to you.

5.We will file a claim on your behalf to all insurers that we are currently participating with. If we are not participating with your insurer, you are responsible for submitting your own claim and paying in full at the time of service. If you are insured by a plan we are contracted with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage.

6. We do not participate with the following insurers, BC Option, Child Health Plus, Empire NYSHIP, Evercare, Family Health Plus, Fidelis, Healthy NY, Medicaid, Medi-Share, MVP Option, Tricare, UHC Community, Valumed, ANY MEDICAID BACKED PLANS.
*Any patient with these plans can be self pay ($90 for 1st visit, $45 for subsequent visits, $10 per Therapy)

7. Returned checks will incur a $25.00 returned check fee. In the event of a second returned check, privilege to pay by check on future visits will be terminated, and you will be expected to pay for services with cash or a credit card.

8. It is understood and agreed that, in the event that any outstanding balance has to be referred to a collection agency or attorney for recovery, the patient will be fully responsible for any cost, including but not limited to attorney's fees. We can work with you to help you to keep this from happening. Please keep in touch if there is a financial hardship.

By signing this document, I understand and agree to fulfill my responsibility as they relate to the above.

Full Name _____ Signature _____

Date _____