New Patient Enrollment Forms

Greetings,

At Optimum Health Chiropractic we take pride in the care for our patients. At every corner you will notice that we tailor to your needs and comfort. One of those ways is by making these forms available to you online. By making this packet available, we hope that this will reduce the wait time when visiting our clinic. Below you will find brief instructions on filing out this packet.

1. **Please fill out paperwork completely.**
2. **On the picture of the body, please put an "X" for pain and an "O" for numbness in the areas you are having trouble with.**
3. **List each complaint separately and as detailed as possible.**

Thank you very much for taking the time to fill these forms out before your first appointment and we also thank you for thinking of us when you are in need. We look forward to providing the absolute best care possible and exceeding your expectations!

Optimum Health Chiropractic Staff

WC	C	PI
MC	PR	BC

Date _____/_____/_____ File # _____

Name_____ Age____ Phone_____Cell_____Work_____
Street Address_____City_____State____Zip _____
Mailing Address _____
E-mail Address _____

Birth Date ____/____/____ Male / Female SS# _____-_____-_____
__Single __Married __Other Employed __Fulltime __Part-time __Student __Disabled
Occupation _____
Employer_____Address_____
Spouse's Name_____ Employer_____
Spouse's Birth Date ____/____/____ SS# _____-____-____

Check any **Allergies**:
__Animals __Aspirin __Bees __Chocolate __Dairy __Dust __Eggs __Latex __Molds __Penicillin __Ragweed/Pollen __Rubber __Seasonal Allergies __Shellfish __Soaps __Wheat __X-Ray Dye __ Other_____

Check any **Surgeries**:
__Back __Brain __Elbow __Foot __Hip __Knee __Neck __Neurological __Shoulder __Wrist __Other:_____

Check **ALL Past Medical History** conditions:
__Ankle Pain __Arm Pain __Arthritis __Asthma __Back Pain __Broken Bones __Cancer __Chest Pain __Depression __Diabetes __Dizziness __Elbow Pain __Epilepsy __Eye/Vision Problems __Fainting __Fatigue __Foot Pain __Genetic Spinal Condition __Hand Pain __Headaches __Hearing Problems __Hepatitis __High Blood Pressure __Hip Pain __HIV __Jaw Pain __Joint Stiffness __Knee Pain __Leg Pain __Menstrual Problems __Mid-Back Pain __Minor Heart Problem __Multiple Sclerosis __Neck Pain __Neurological Problems __Pacemaker __Parkinson's __Polio __Prostate Problems __Shoulder Pain __Significant Weight Change __Spinal Cord Injury __Sprain/Strain __Stroke/Heart Attack __Other: _____

List all medications you are currently taking: _____

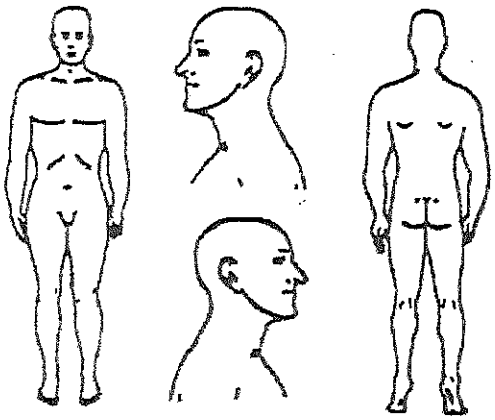
Person to Contact	Name	
In Emergency	Address	Phone

Nearest Relative Not Living With You_____ Phone_____
Nearest Friend Not Living With You_____ Phone_____
Physician_____ Phone_____

__CASH __CHECK __CREDIT CARD

Date of last physical examination: _____ Do you smoke? __No __Yes
Do you drink alcohol? __No __Yes – How many per day? _____
Do you drink caffeine? __No __Yes – How many per day? _____
Do you exercise? __No __Yes (what forms and how often): _____

Please mark ALL areas of **Pain** with a "X" Mark **Numbness** with an "O"



Main reason for consulting the office:
__ Become pain free
__ Explanation of my condition
__ Learn how to care for my condition
__ Reduce symptoms
__ Resume normal activity level

What is your major complaint? _____ Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? __GETTING BETTER __GETTING WORSE __NOT CHANGING

Have you had this condition in the past? YES / NO

How often do you experience your symptoms?

__Constantly (76%-100%) __Frequently (51%-75%)

__Occasionally (26%-50%) __Intermittently (0-25%)

Describe the nature of your symptoms: __Sharp __Dull __Numb __Burning __Shooting __Tingling __Radiating Pain __Tightness __Stabbing __Throbbing __Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

__1 __2 __3 __4 __5 __6 __7 __8 __9 __10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) __1 __2 __3 __4 __5 __6 __7 __8 __9 __10

What activities aggravate your condition (working, exercising, etc)? _____

What makes your pain better (ice, heat, massage, etc.)? _____

What is your SECOND complaint? _____ Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? __GETTING BETTER __GETTING WORSE __NOT CHANGING

Have you had this condition in the past? YES / NO

How often do you experience your symptoms?

__Constantly (76%-100%) __Frequently (51%-75%)

__Occasionally (26%-50%) __Intermittently (0-25%)

Describe the nature of your symptoms: __Sharp __Dull __Numb __Burning __Shooting __Tingling __Radiating Pain __Tightness __Stabbing __Throbbing __Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

__1 __2 __3 __4 __5 __6 __7 __8 __9 __10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) __1 __2 __3 __4 __5 __6 __7 __8 __9 __10

What activities aggravate your condition (working, exercising, etc)? _____

What makes your pain better (ice, heat, massage, etc.)? _____

What is your THIRD complaint? _____ Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? __GETTING BETTER __GETTING WORSE __NOT CHANGING

Have you had this condition in the past? YES / NO

How often do you experience your symptoms?

__Constantly (76%-100%) __Frequently (51%-75%)

__Occasionally (26%-50%) __Intermittently (0-25%)

Describe the nature of your symptoms: __Sharp __Dull __Numb __Burning __Shooting __Tingling __Radiating Pain __Tightness __Stabbing __Throbbing __Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

__1 __2 __3 __4 __5 __6 __7 __8 __9 __10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) __1 __2 __3 __4 __5 __6 __7 __8 __9 __10

What activities aggravate your condition (working, exercising, etc)? _____

What makes your pain better (ice, heat, massage, etc.)? _____

Effective Date April 28, 2014

OPTIMUM HEALTH CHIROPRACTIC

HIPAA Notice of Privacy Practices

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

Our Obligation

We are required by law to maintain the privacy of your protected health information. We are also required to provide you with these notices of our legal duties and privacy practices regarding health information about you, and follow the terms of our notice that is currently in effect. If we make a change to the terms of our privacy agreement we will notify you in writing when you come in for treatment or by mail. If we make a change in our privacy terms the changes will apply for all of your health information in our files.

Uses and Disclosure

Except for the purposes described below, we will use and disclose health information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer, Dr. Shaine E. Rider.

1) Your chiropractor or a staff member may have to disclose your health information including all of your clinical records to another health care provider or hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.
2) Our insurance and billing staff may have to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, a HMO, a PPO or your employer, if they are potentially responsible for the payment of your services.
3) Your chiropractor and members of the staff may need to use your health information, examination and treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run our practice.
4) Your chiropractor and members of the practice staff may need to use your name, address, phone number and your clinical records to contact you to provide appointment reminders or information about 1) 2) or 3). If you are not home to receive an appointment reminder, a message will be left on your answering machine. You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives, or other health related information. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.
5) When appropriate, we may share health information with a person who is involved in your medical care or payment for your care, such as family, or close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.
6) Under certain circumstances, we may use and disclose health information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another for the same condition. Before we use or disclose health information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any health information.

Permitted uses and disclosures without your consent or authorizations

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

1) We are permitted to use or disclose your health information if we are providing health care services to you based on the orders of another health care provider.
2) We are permitted to use or disclose your health information if we provide health care services to you as an inmate.
3) We are permitted to use or disclose your health information if we provide health care services to you in an emergency.
4) We are permitted to use or disclose your health information if we are required by law to treat you and we are unable to obtain your consent after attempting to do so.
5) We are permitted to use or disclose your health information if there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
6) If you are an organ donor, we may use or release health information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissue to facilitate organ, eye or tissue donation and transplantation.
7) If you are a member of the armed forces, we may release health information as required by military command authorities. We also may release health information to the appropriate foreign military authority if you are a member of a foreign military.
8) We may release health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
9) We may disclose health information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
10) We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.
11) We may use or disclose your protected health information to provide legally required notices of unauthorized access to or disclosure of your health information.
12) If you are involved in a lawsuit or dispute, we may disclose health information in response to a court or administrative order. We may also disclose health information in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
13) We may release health information if asked by law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.
14) We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release health information to funeral directors as necessary for their duties.
15) We may release health information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.
16) We may disclose health information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.
17) We may release health information to business associates that perform functions on our behalf, for example, billing services.

Other than the circumstances described in the proceeding examples, and other use or disclosure of your health information will only be made with your written authorization.

Uses and Disclosures that require us to give you an opportunity to object and opt

The following uses and disclosures of your protected health information will be made only with your written authorization:

1) Uses and disclosures of protected health information for marketing purposes; and
2) Disclosures that constitute a sale of your protected health information

Other uses and disclosures of protected health information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our privacy officer and we will no longer disclose protected health information under the authorization, but disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation. If there are health care providers, hospitals, employers, insurers or other individuals or organizations to whom you do not want us to disclose your health information; please let us know, in writing, what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider.

You have the following rights regarding health information we have about you:

1) You have the right to inspect and/or copy your health information for six years from the date that the record was created or as long as the information remains in our files.
2) We normally provide information about your health to you in person at the time you receive chiropractic services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services that we provide other than your home or if you would like the information in a different form. To help us respond to your needs, please make any request in writing.
3) You have the right to request that we amend your health information for six years from the date the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing, to Dr. Shaine E. Rider, and for you to give us a reason to support the change you are requesting us to make.
4) You have the right to request a list of certain disclosures we make of health information for purposes other than treatment, payment and health care operations or for which you provide written authorization. To request an accounting of disclosures, you must make your request, in writing, to Dr. Shaine E. Rider.
5) You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website, www.ohchiro.org. To obtain a paper copy of this notice, make a written request to Dr. Shaine E. Rider.
6) You have the right to request a restriction or limitation on the health information we use or disclose for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to Dr. Shaine E. Rider. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your protected health information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.
7) If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your protected health information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations and we will honor that request.
8) If your protected health information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your protected health information in the form or format you request, if it is readily producible in such form or format. If the protected health information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.
9) You have the right to be notified upon a breach of any of your unsecured protected health information.

Re-disclosure

Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

Changes to this notice

We reserve the right to change this notice and make the new notice apply to health information we already have as well as any information we receive in the future. We will post a copy of our current notice at your office. The notice will contain the effective date on the first page, in the top right-hand corner.

You may complain to us or to the secretary for health and human services if you feel that we have violated your privacy rights. We respect your right to file a complaint at any time; written comments should be addressed to:

Optimum Health Chiropractic
601 W. College Street
Lake Charles, LA 70605

You will not be penalized for filing a complaint.

If you would like further information about our privacy policies and practices, please contact one of our staff members at (337)480-0027.

This notice is effective as of ____/____/____. This notice will expire seven years after the date upon which the record was created. By signing below, I acknowledge that I have received a copy of this notice.

_____ ____/____/____
Patient Name Printed Date

_____ _____
Patient Signature Authorized Provider Representative

_____ _____
Personal Representative Printed Personal Representative Signature

Assignment, Lien, and Authorization
Insurance Benefits
Optimum Health Chiropractic Clinic

THIS AGREEMENT is entered into by and between _____, hereinafter sometimes referred to as "Patient", and Optimum Health Chiropractic Clinic hereinafter sometimes referred to as "Doctor".

IT IS AGREED THAT:

1. The patient hereby instructs all insurance carriers and other parties that may be responsible for the payment of some or all of the charges incurred by Patient for chiropractic services rendered by Doctor, to make any such payments directly to the Doctor.
2. The Patient hereby grants to Doctor a lien against any amounts that may be payable regarding any claim the Patient may have against any person whose acts or omissions may have resulted in injuries or illness sustained by the Patient. The amount of any such lien shall be limited to the total amount of charges incurred by the Patient for services rendered by Doctor.
3. The Patient hereby grants to Doctor a lien against any amounts that may be payable under any insurance policy or health care plan, or a result of services rendered by the Doctor to the Patient. The amount of any such lien shall be limited to the total amount of the charges incurred by the Patient for services rendered by Doctor.
4. The Patient hereby assigns to the Doctor his rights to any and all benefits or proceeds that may be payable to Patient under the terms of any insurance policy or health care plan as a result of services rendered by the Doctor.
5. The Patient hereby assigns to the Doctor any and all rights that he may have against any insurance company or health care plan, or other person or entity that may be legally responsible to pay some or all of the charges incurred by the Patient for services rendered by the Doctor. These assignments shall not exceed that amount of charges incurred by the Patient for services rendered by the Doctor.
6. The Patient agrees that if the Patient receives any payment (whether by check or otherwise) from an insurance company, or other person, for services rendered by Doctor to Patient, the Patient will immediately deliver any such payments to Doctor.
7. In some circumstances, an insurance company or other person may require that the Patient designate the Doctor as his agent (referred to as "attorney in fact") in order to collect amounts payable for services rendered by Doctor to Patient. Accordingly, the Patient hereby agrees that, for the sole purpose of collecting any amounts payable from insurance companies or other persons that may be payable to Patient for services rendered by Doctor. Such reasonable powers shall include, in required, the power and authority to demand, request, sue for, collect, endorse, sign, and receive payments.
8. The Patient hereby expressly authorizes to Doctor to request and receive from any insurance company, employer, or other person, copies of any documents, insurance policies, agreements, or information that reasonably relates to the payment of person, copies of any documents, insurance policies, or information that may reasonably relate to the payment of charges incurred by Patient for services rendered by Doctor.
9. The Patient authorizes the Doctor to release any information to insurance companies, or other persons, that may reasonably relate to the payment of charges incurred by Patient for services rendered by Doctor. Such information shall include, without limitation, copies of charts and records maintained by Doctor with respect to Patient, x-ray reports, laboratory reports and test results.
10. The Doctor is authorized to submit a copy of this Assignment Agreement to any insurance company, or other person, for the purpose of obtaining payment of the charges incurred by Patient for services rendered by Doctor.
11. The Patient acknowledges that this Agreement has been entered into as a convenience for Patient, so that Patient will not be required to pay all fees, costs and charges at the time medical services are rendered. However, the Patient is responsible for the payment of all fees, costs, and charges incurred by Patient for services rendered by Doctor, according to the schedule of payments that may be agreed upon by Doctor and Patient.
12. Any provision of this Agreement shall remain enforceable.
13. The following general provisions shall be applicable to this Agreement:
    a) This Agreement shall be binding and shall inure to the benefit of the parties to this Agreement and their respective heirs, executors, administrators, successors and assigns.
    b) This Agreement is made and will be performed in the State of Louisiana and shall be construed and enforced in accordance with and governed by the laws of this State.
    c) The parties agree, without any further consideration, to execute and deliver all such further assignments, papers, documents, or other assurances reasonably necessary to carry into effect, within Agreement.
    d) Should any action be instituted to enforce any provisions of the Agreement, the prevailing party shall be entitled to receive his/her reasonable attorney's fees and costs.
    e) This Agreement contains the complete agreement between the parties and no supplement, amendment or commitment will be binding, unless in writing and signed by the obligated party

The undersigned patient, parent or guardian hereby agrees that, if this account is referred to an attorney or any collection agency collection, the undersigned will pay all costs of collection, including reasonable attorney's fees which are hereby stipulated to be one-third of the amount due or a minimum of $500.00, whichever is greater. If the account is not paid within one month from the date of service performed, the undersigned agrees to pay interest on the balance due at the rate of 1 ½% per month (18% annual percentage rate) until the account is paid in full. It is expressly understood and agreed that the exclusive venue and jurisdiction for collection of unpaid accounts shall be given to Lake Charles City Court, Lake Charles, Louisiana.

_____ _____/_____/_____ _____
Patient's Signature Date Witness

OPTIMUM HEALTH CHIROPRACTIC
SHAINE E. RIDER, D.C.

Office: 337-480-0027
Fax: 337-480-0499

601 W. College Street
Lake Charles, LA 70605
info@ohchiro.org

No Show Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. We reserve the right to charge for these occurrences.

As of Thursday, March 20, 2014, you must give us an **advanced notice** to cancel appointments. Failure to do so will result in a $25 fee charged to your account.

By signing below, I acknowledge that I have read and understand this policy.

_____ _____

Patient Signature Date

_____

Patient Name (Printed)

_____ _____

Witness Signature Date

Appointment Reminders and Health Care Information Authorization

Optimum Health Chiropractic
Dr. Shaine Rider
601 W College Street
Lake Charles, LA 70605
(337) 480-0027

Your Chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, or we are unable to reach you by mobile phone, a message will be left on your answering machine or with the person who answers the telephone. You also give us authorization to call you at work and if you are unavailable, leave a message with a co-worker or on your answering machine/voice mail. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address or handed in at the office. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this information. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

This notice is effective as of _____. This authorization will expire six years after the date on which you last received services.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

_____ ____/____/____
Patient Name Printed Date

_____ _____
Patient Signature Authorization Provider Representative

_____ _____
Personal Representative Printed Personal Representative Signature

Description of Personal Representative's Authority to Act for the Patient

_____

Optimum Health Chiropractic
601 W College Street
Lake Charles, LA 70605
Shaine Rider, D.C.

Dear Patient:

Every type of health care is associated with some risk of a potential problem. This includes chiropractic health care. Although research has shown that chiropractic is one of the safest forms of treatment, we want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

Chiropractic adjustments are the moving of bones with the doctor's hands or with the use of a mechanical device. Frequently, adjustments create a "pop" or "clicking" sound/sensation in the area being treated.

In this office we use trained personnel to assist the doctor with portions of your consultation, examination, x-ray taking, physical therapy application, traction, massage therapy, exercise instruction, etc. Occasionally, when your doctor is unavailable, another clinic doctor will treat you on that day.

Soreness: It is common for chiropractic adjustments, traction, massage therapy, exercise, etc. to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please do tell your doctor about it.

Physical Therapy Burns: Some of the machines we use generate heat. We also use both heat and ice, and recommend them for home care on occasion. Everyone's skin has different sensitivity to these modalities, and rarely, either heat or ice can burn or irritate the skin. The result is a temporary increase in skin pain and there may even be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their probability.

Rib Fractures: The ribs are found only in the thoracic spine or middle back. They extend from your back to your front chest area. Rarely a chiropractic adjustment will crack a rib, and this is referred to as a fracture. This occurs only on patients who have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients very carefully, and especially those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

Soft Tissue Injury: Soft tissues primarily refer to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely a chiropractic adjustment, traction, massage therapy, etc., may tear some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long-term effects for the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

Disc Herniations: Disc herniations that create pressure on the spinal nerves or the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc. This includes both the neck and back. Yet, occasionally chiropractic treatment (adjustments, traction, etc.) will aggravate the problem and rarely surgery may become necessary for correction. Rarely, chiropractic adjustments may also cause a disc problem if the disc is in a weakened condition. These problems occur so rarely that there are no available statistics to quantify their probability.

Stroke: Stroke is the most serious consequence associated with chiropractic adjustments. The most recent studies (Journal of the CCA. Vol. 37. No2. June 1993) estimate that the incidence of this type of stroke is 1 per every 3 million upper neck adjustments. This means that an average chiropractor would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke. Stroke means that a portion of the brain does not receive enough oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. Chiropractic adjustments have been associated with strokes that arise from the vertebral artery only; this is because the vertebral artery is actually found inside the neck vertebrae. The adjustment that is related to the vertebral artery stroke is called the "extension-rotation-thrust atlas adjustment". We do not do this type of adjustment on patients. Other types of neck adjustments may also potentially be related to vertebral artery strokes, but no one is certain.

Other Problems: There may be other problems or complications that may arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipated and/or explain them all to advance of treatment.

Chiropractic is a system of health care delivery, and, therefore, as with any health care delivery system, we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will give you our best care, and if results are not acceptable, we will refer you to another provider, whom we feel will assist your situation.

If you have any questions on the above, please ask your doctor. When you have a full understanding, please sign and date below.

_____ ____/____/____

Patient's Name (Print) Date

_____ _____

Patient's Signature Parent or Guardian Signature for Minor