Plaza Chiropractic and Sports Medicine

1314 Englishtown Rd, Old Bridge, NJ 08857
P (732) 723-0023 ~ F (732) 723-1614

General Information

Patient Name:		Social Security #:	
Sex M / F	Date of Birth:	Age:	
Mailing Address:	City:	State:	Zip code:
Email Address:	May we contact you via email?: Y / N	May we contact you via text Message?: Y / N	
Primary Phone #:	Secondary Phone #:	Cell Phone #:	
Employer:	Occupation:		
Have you ever been to a Chiropractor ? Y / N			
Number of Children:	Marital Status: S / M / D / W		

In Case of Emergency

Contact name:		
Relationship:	Address:	
Home Phone:	Cell Phone:	Work Phone:

How did you hear about our office?			
Who may we contact regarding your care/billing?	Contact Name:	Phone:	

Primary Insurance Information

Primary Insurance Company Name:		Subscriber Address:	
ID#:	Group #:	Subscriber Name:	Subscriber SSN:
		Subscriber Phone:	Subscriber Dob:

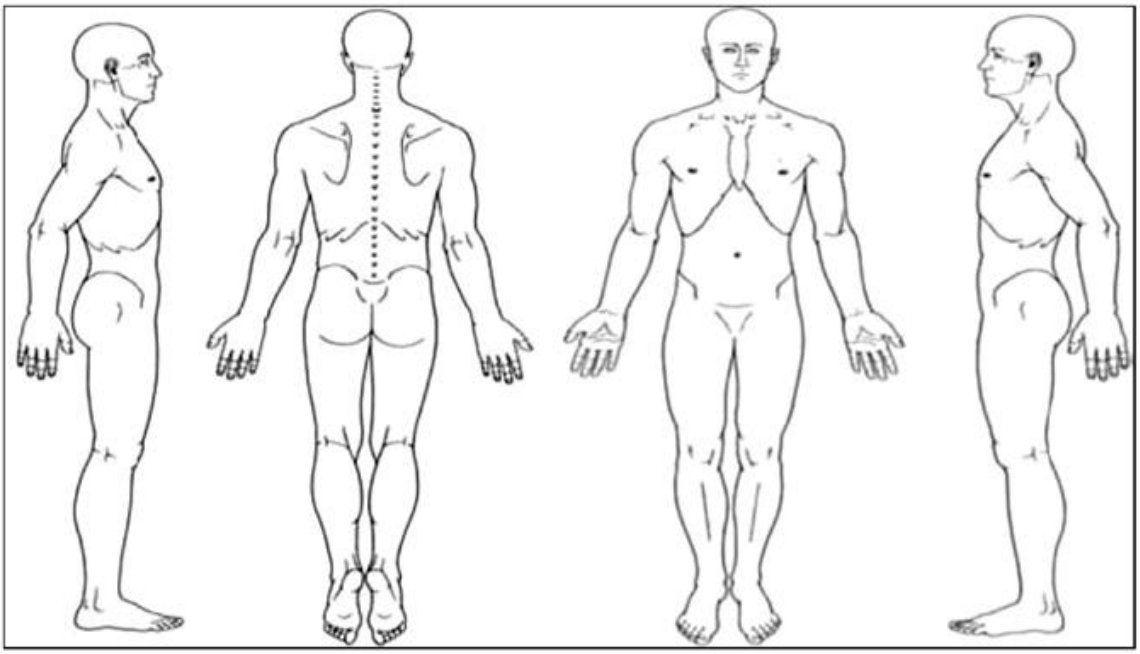
Secondary Insurance Information

Secondary Insurance Company Name:		Subscriber Address:	
ID#:	Group #:	Subscriber Name:	Subscriber SSN:
		Subscriber Phone:	Subscriber Dob:

Todays Visit

Reason for Today's Visit:				
How long have you had this problem:	YEARS	MONTHS	WEEKS	
What makes it better or worse:				Rate the Pain : _____ (0 = nothing, 10 = worst imaginable)

On the diagram below, please indicate where you are experiencing pain right now. Please use key to the right of the diagram to further explain what type of sensations you are experiencing in each area.



A = Ache

B = Burning

N = Numbness

P = Pins & Needles

S = Stabbing

O = Other

Are you a: (Please circle one) Current Smoker Former Smoker Never Smoked Pipe Smoker Cigar Smoker If yes, how much did you smoke? 3 cigarettes or less per day ½ A pack per day more than a pack per day Vape Smokers+-
Do you drink alcohol? (Please circle one) YES NO If yes, How frequently? Socially Only Several times per week Everyday
Do you or have you ever used illicit drugs? (Please circle one) YES NO If yes, what kind? IV DRUGS PILLS MARIJUANA OTHER
Are you Currently participating in sports? (Please circle one) YES NO If yes, what sport? GOLF TENNIS FOOTBALL SOCCER BASEBALL BASKETBALL OTHER

Please circle any of the following symptoms that you've experienced recently:			
Constitutional:	Fever	Night sweats	Weight Loss
Eyes:	Red Eyes	Blurred Vision	Vision Loss
Ears / Nose / Mouth:	Nose Bleeds	Sore Throat	Hearing Loss
Cardiovascular:	Chest Pains	Palpitations	Leg Swelling
Respiratory:	Shortness of Breath	Chronic Cough	Wheezing
Gastrointestinal:	Nausea	Vomiting	Diarrhea
Genitourinary:	Burning w/ Urination	Blood in Urine	Urinary Inconsistency
Skin:	Rash	Hives	Skin Infection
Neurological:	Headache	Tremor	Seizures
Psychiatric:	Depression	Panic Attacks	Suicidal Ideation
Endocrine:	excessive Thirst	Cold Intolerance	Excessive Sweating
Hematological:	Easy Bruising	Swollen Glands	Easy Bleeding
Allergy / Immune:	Runny Nose	Sinus Congestion	Itchy Eyes

Past Medical History (Please circle one)

High Blood Pressure	Coronary Artery Disease	Vascular Disease	Emphysema
Diabetes	Congestive Heart Failure	Heart Disease / Attack	Thyroid Disease
Lyme's Disease	Bleeding Disorder	Seizures	Gastric Reflux
Multiple Sclerosis	Enlarged Prostate	Hepatitis	Liver Disease
Osteoarthritis	Rheumatoid Arthritis	Stomach Ulcers	Kidney Disease
Asthma	COPD	Cancer	Scoliosis
Depression	Other:		

Family History (Please circle one)

Bleeding Disorder	Coronary Artery Disease	Hepatitis	Cancer
heart Disease / Attacks	Seizures	Lung Disease	Rheumatoid Arthritis
Kidney Disease	Malignant Hyperthermia	Scoliosis	Asthma
Other:			

Surgical History (Please Circle one)

SURGERY	DATE	SURGERY	DATE
Knee Arthroscopy (right / Left)		Shoulder Arthroscopy (right / Left)	
Spine Surgery		Joint Replacement Surgery	
Hernia Repair		Laparotomy	
Eye Surgery		Thyroid Surgery	
Peripheral Bypass Surgery		Cardiac Catheterization	
Coronary Artery Bypass Surgery		Hysterectomy	
Pacemaker		defibrillator	

Please list any other surgery you may have had in the past not previously mentioned: _____

_____

_____

Please list any Medications you are on, or have taken in the past 6 months: _____

_____

_____

Please list anything you may have an allergic reaction from: _____

_____

_____

Patient Signature: _____ Date: _____

Parent / Guardian Signature: _____ Date: _____

Reviewed By Physician: _____ Date: _____

FINANCIAL POLICY AGREEMENT / ASSIGNMENT OF BENEFITS

THANK YOU FOR CHOOSING PLAZA CHIROPRACTIC & SPORTS MEDICINE AS YOUR HEALTHCARE PROVIDER. WE ARE COMMITTED TO PROVIDING EXCELLENT CARE TO ALL OF OUR PATIENTS AND WE WILL ALWAYS DO OUR BEST TO ACHIEVE THIS GOAL.

PLAZA CHIROPRACTIC & SPORTS MEDICINE IS A PRIVATE PROFESSIONAL ENTITY, IS CONTRACTED WITH SELECT INSURANCE PLANS. EVEN THOUGH WE DO PARTICIPATE IN MOST INSURANCE PLAN'S PROVIDER NETWORKS, WE PLEDGE TO HELP YOU UNDERSTAND AND MANAGE THE FINANCIAL ASPECTS ASSOCIATED WITH PROVIDING YOU THE VERY BEST CARE AND ATTENTION YOU DESERVE.

MOST INSURANCE PLANS ALLOW PATIENTS TO SELECT THEIR OWN TREATING PHYSICIAN. TO HELP YOU UNDERSTAND YOUR RESPONSIBILITIES, WE WILL INQUIRE AS TO YOUR PLAN'S IN-NETWORK BENEFITS, AND EXPLAIN WHAT, IF ANY, FINANCIAL OBLIGATIONS YOU WILL HAVE FOR OUR SERVICES.

OUR INDEPENDENCE IS A HALLMARK TRAIT OF OUR PRACTICE. AS AN IN-NETWORK PROVIDER, THE COURSE OF TREATMENT WE PROVIDE WILL NOT BE LIMITED TO WHAT AN INSURANCE PLAN REPRESENTATIVE WILL APPROVE BUT WILL INSTEAD BE BASED SOLELY UPON THE STATE-OF-THE-ART CARE THAT YOUR PHYSICIAN RECOMMENDS.

ALL CHARGES WILL BE SUBMITTED TO YOUR INSURANCE CARRIER ON YOUR BEHALF AS AN IN-NETWORK-PROVIDER. YOU MAY BE RESPONSIBLE FOR YOUR DEDUCTIBLE AND CO-INSURANCE ON ALLOWED PAYMENTS UP TO YOUR OUT-OF-POCKET MAXIMUM ACCORDING TO YOUR IN-NETWORK INSURANCE POLICY. IN A FEW CASES, HOWEVER, A PARTICULAR PLAN MAY NOT PROVIDE REASONABLE AND CUSTOMARY PAYMENT, IN WHICH CASE YOU MAY BE RESPONSIBLE FOR SOME OF THE DIFFERENCE BETWEEN WHAT IS BILLED AND WHAT YOUR INSURANCE PLAN ALLOWS FOR PAYMENT.

MOST INSURANCE CARRIERS WILL SEND PAYMENTS DIRECTLY TO PLAZA CHIROPRACTIC AND SPORTS MEDICINE, BUT IN SOME CASES YOUR INSURANCE COMPANY MAY SEND PAYMENT FOR OUR SERVICES DIRECTLY TO YOU. YOU AGREE TO RELINQUISH ALL PAYMENTS THAT YOU RECEIVE FROM YOUR INSURANCE COMPANY FOR OUR SERVICES TO PLAZA CHIROPRACTIC & SPORTS MEDICINE. FAILURE TO DO SO WILL RESULT IN LEGAL ACTION.

BY SIGNING BELOW, YOU ATTEST THAT YOU COMPLETELY UNDERSTAND AND AGREE WITH OUR FINANCIAL POLICY AS DESCRIBED ABOVE FOR THE SERVICES PROVIDED BY PLAZA CHIROPRACTIC & SPORTS MEDICINE AND ITS PROFESSIONALS.

ASSIGNMENT OF BENEFITS

PATIENT NAME : _____ DATE: _____

I IRREVOCABLY ASSIGN PLAZA CHIROPRACTIC & SPORTS MEDICINE ALL MY RIGHTS AND BENEFITS UNDER ANY INSURANCE CONTRACTS FOR PAYMENT FOR SERVICES RENDERED TO ME BY PLAZA CHIROPRACTIC & SPORTS MEDICINE. I IRREVOCABLY AUTHORIZE ALL INFORMATION REGARDING MY BENEFITS UNDER ANY INSURANCE POLICY RELATING TO ANY CLAIMS BY PLAZA CHIROPRACTIC & SPORTS MEDICINE TO BE RELEASED TO PLAZA CHIROPRACTIC & SPORTS MEDICINE. I IRREVOCABLY AUTHORIZE PLAZA CHIROPRACTIC & SPORTS MEDICINE TO FILE INSURANCE CLAIMS ON BEHALF FOR SERVICES RENDERED TO ME. I IRREVOCABLY DIRECT THAT ALL SUCH PAYMENTS TO GO DIRECTLY TO PLAZA CHIROPRACTIC & SPORTS MEDICINE. I IRREVOCABLY AUTHORIZE PLAZA CHIROPRACTIC & SPORTS MEDICINE TO ACT ON MY BEHALF AND REPORT ANY SUSPECTED VIOLATION OF PROPER CLAIMS PRACTICES TO THE PROPER REGULATORY AUTHORITIES. THIS ASSIGNMENT OF BENEFITS HAS BEEN EXPLAINED TO MY FULL SATISFACTION, AND I UNDERSTAND ITS NATURE AND EFFECT.

X_____

PATIENT SIGNATURE

WOULD YOU LIKE MORE INFORMATION ON:

- ☐ OCCUPATIONAL THERAPY
- ☐ ALLERGY TREATMENTS
- ☐ VARICOSE VEIN SERVICES
- ☐ MEDICAL PAIN MANAGEMENT
- ☐ PHYSICAL THERAPY
- ☐ SPORTS INJURIES
- ☐ OTHER: _____

NOTICE OF PRIVACY PRACTICES

PLAZA CHIROPRACTIC & SPORTS MEDICINE
1314 ENGLISHTOWN RD. OLD BRIDGE, NJ 08857
(732) 723-0023

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

YOUR RIGHTS

WHEN IT COMES TO YOUR HEALTH INFORMATION, YOU HAVE CERTAIN RIGHTS. THIS SECTION EXPLAINS YOUR RIGHTS AND SOME OF OUR RESPONSIBILITIES TO HELP YOU.

GET AN ELECTRONIC OR PAPER COPY OF YOUR MEDICAL RECORD:

YOU CAN ASK TO SEE OR GET AN ELECTRONIC OR PAPER COPY OF YOUR MEDICAL RECORD AND OTHER HEALTH INFORMATION WE HAVE ABOUT YOU. ASK US HOW TO DO THIS. WE WILL PROVIDE A COPY OR A SUMMARY OF YOUR HEALTH INFORMATION, USUALLY WITHIN 30 DAYS OF YOUR REQUEST. WE MAY CHARGE A REASONABLE, COST-BASED FEE.

ASK US TO CORRECT YOUR MEDICAL RECORD:

YOU CAN ASK US TO CORRECT HEALTH INFORMATION ABOUT YOU THAT YOU THINK IS INCORRECT OR INCOMPLETE. ASK US HOW TO DO THIS. WE MAY SAY "NO" TO YOUR REQUEST, BUT WE'LL TELL YOU WHY IN WRITING WITHIN 60 DAYS.

REQUEST CONFIDENTIAL COMMUNICATIONS:

YOU CAN ASK US TO CONTACT YOU IN A SPECIFIC WAY (FOR EXAMPLE, HOME OR OFFICE PHONE) OR TO SEND MAIL TO A DIFFERENT ADDRESS. WE WILL SAY "YES" TO ALL REASONABLE REQUESTS.

ASK US TO LIMIT WHAT WE USE OR SHARE:

YOU CAN ASK US NOT TO USE OR SHARE CERTAIN HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR OUR OPERATIONS. WE ARE NOT REQUIRED TO AGREE TO YOUR REQUEST, AND WE MAY SAY "NO" IF IT WOULD AFFECT YOUR CARE. IF YOU PAY FOR SERVICE OR HEALTH CARE ITEM OUT-OF-PACKET IN FULL, YOU CAN ASK US NOT TO SHARE THAT INFORMATION FOR THE PURPOSE OF PAYMENT OR OUR OPERATIONS WITH YOUR HEALTH INSURER. WE WILL SAY "YES" UNLESS A LAW REQUIRES US TO SHARE THAT INFORMATION.

GET A LIST OF THOSE WITH WHOM WE'VE SHARED INFORMATION:

YOU CAN ASK FOR A LIST (ACCOUNTING) OF THE TIMES WE'VE SHARED YOUR HEALTH INFORMATION FOR SIX YEARS PRIOR TO THE DATE YOU ASK, WHO WE SHARED IT WITH AND WHY. WE WILL INCLUDE ALL THE DISCLOSURES EXCEPT FOR THOSE ABOUT TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, AND CERTAIN OTHER DISCLOSURES (SUCH AS ANY YOU ASKED US TO MAKE). WE'LL PROVIDE ONE ACCOUNTING A YEAR FOR FREE BUT WILL CHARGE A REASONABLE, COST-BASED FEE IF YOU ASK FOR ANOTHER ONE WITHIN 12 MONTHS.

GET A COPY OF THIS PRIVACY NOTICE:

YOU CAN ASK FOR A PAPER COPY OF THIS NOTICE AT ANY TIME, EVEN IF YOU HAVE AGREED TO RECEIVE THE NOTICE ELECTRONICALLY, WE WILL PROVIDE YOU WITH A PAPER COPY PROMPTLY.

CHOOSE SOMEONE TO ACT FOR YOU:

IF YOU HAVE GIVEN SOMEONE MEDICAL POWER OF ATTORNEY OR IF SOMEONE IS YOUR LEGAL GUARDIAN, THAT PERSON CAN EXERCISE YOUR RIGHTS AND MAKE CHOICES ABOUT YOUR HEALTH INFORMATION. WE WILL MAKE SURE THE PERSON HAS THIS AUTHORITY AND CAN ACT FOR YOU BEFORE WE TAKE ANY ACTION.

FILE A COMPLAINT IF YOU FEEL YOUR RIGHTS ARE VIOLATED:

YOU CAN COMPLAIN IF YOU FEEL WE HAVE VIOLATED YOUR RIGHTS BY CONTACTING US. YOU CAN FILE A COMPLAINT WITH THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES OFFICE FOR CIVIL RIGHTS BY SENDING A LETTER TO 200 INDEPENDENCE AVENUE, S.W., WASHINGTON, D.C. 20201, CALLING 1-877-696-6775, OR VISITING WWW.HHS.GOVE/OCR/PRIVACY/HIPPA/COMPLAINTS/. WE WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT.

YOUR CHOICES

FOR CERTAIN HEALTH INFORMATION, YOU CAN TELL US YOUR CHOICES ABOUT WHAT WE SHARE. IF YOU HAVE A CLEAR PREFERENCE FOR HOW WE SHARE YOUR INFORMATION IN THE SITUATIONS DESCRIBED BELOW, TALK TO US. TELL US WHAT YOU WANT US TO DO, AND WE WILL FOLLOW YOUR INSTRUCTIONS.

IN THESE CASES, YOU HAVE BOTH THE RIGHT AND CHOICE TO TELL US TO:

SHARE INFORMATION WITH YOUR FAMILY, CLOSE FRIENDS, OR OTHERS INVOLVED IN YOUR CARE. SHARE INFORMATION IN A DISASTER RELIEF SITUATION. INCLUDE YOUR INFORMATION IN A HOSPITAL DIRECTORY. CONTACT YOU FOR FUNDRAISING EFFORTS. IF YOU ARE NOT ABLE TO TELL US YOUR PREFERENCE, FOR EXAMPLE IF YOU ARE UNCONSCIOUS, WE MAY GO AHEAD AND SHARE YOUR INFORMATION IF WE BELIEVE IT IS IN YOUR BEST INTEREST. WE MAY ALSO SHARE YOUR INFORMATION WHEN NEEDED TO LESSEN A SERIOUS AND IMMINENT THREAT TO HEALTH OR SAFETY.

IN THESE CASES WE NEVER SHARE YOUR INFORMATION UNLESS YOU GIVE US WRITTEN PERMISSION:

MARKETING PURPOSES. SALE OF YOUR INFORMATION. MOST SHARING OF PSYCHOTHERAPY NOTES.

IN THE CASE OF FUNDRAISING:

WE MAY CONTACT YOU FOR FUNDRAISING EFFORTS, BUT YOU CAN TELL US NOT TO CONTACT YOU AGAIN.

OUR USES AND DISCLOSURES

HOW DO WE TYPICALLY USE OR SHARE YOUR HEALTH INFORMATION? WE TYPICALLY USE OR SHARE YOUR HEALTH INFORMATION IN THE FOLLOWING WAYS:

TREAT YOU:

WE CAN USE YOUR HEALTH INFORMATION AND SHARE IT WITH OTHER PROFESSIONALS WHO ARE TREATING YOU. EXAMPLE: A DOCTOR TREATING YOU FOR AN INJURY ASKS ANOTHER DOCTOR ABOUT YOUR OVERALL HEALTH CONDITION.

RUN OUR ORGANIZATION:

WE CAN USE AND SHARE YOUR HEALTH INFORMATION TO RUN OUR PRACTICE, IMPROVE YOUR CARE, AND CONTACT YOUR WHEN NECESSARY. EXAMPLE: WE USE HEALTH INFORMATION ABOUT YOU TO MANAGE YOUR TREATMENT AND SERVICES.

BILL FOR YOUR SERVICES:

WE CAN USE AND SHARE YOUR HEALTH INFORMATION TO BILL AND GET PAYMENT FORM HEALTH PLANS OR OTHER ENTITIES. EXAMPLE: WE GIVE INFORMATION ABOUT YOU TO YOUR HEALTH INSURANCE PLAN SO IT WILL PAY FOR YOUR SERVICES.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues:

We can share health information about you for certain situations such as preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, preventing or reducing a serious threat to anyone's health or safety.

Do research:

We can use or share your information for health research.

Comply with the law:

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests:

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director:

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests:

We can use or share health information about you for worker's compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, for special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions:

We can share heath information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain to privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of This Notice:

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request.

Contact Person:

All questions concerning this notice, or requests made pursuant to it, should be addressed to: Tracie Cuccia
EMAIL- plazachiro@optonline.net .

Patient Acknowledgment:

I acknowledge that I have reviewed this office's Notice of Privacy Practices, acknowledge that I may refuse to sign this acknowledgment if I wish, and agree to the liability limitations explained therein. I have the right to obtain a paper copy of this notice.

_____

Patient Printed Name

_____

Patient Signature or legal representative

_____

If legal representative, state relationship

_____

Date

PLAZA CHIROPRACTIC & SPORTS MEDICINE
INFORMED CONSENT TO CARE

YOU ARE THE DECISION MAKER FOR YOUR HEALTH CARE. PART OF OUR ROLE IS TO PROVIDE YOU WITH INFORMATION TO ASSIST YOU IN MAKING INFORMED CHOICES. THIS PROCESS IS OFTEN REFERRED TO AS "INFORMED CONSENT" AND INVOLVES YOUR UNDERSTANDING AND AGREEMENT REGARDING THE CARE WE RECOMMEND, THE BENEFITS AND RISKS ASSOCIATED WITH THE CARE, ALTERNATIVES, AND THE POTENTIAL EFFECT ON YOUR HEALTH IF YOU CHOOSE NOT TO RECEIVE THE CARE.

WE MAY CONDUCT SOME DIAGNOSTIC OR EXAMINATION PROCEDURES IF INDICATED. ANY EXAMINATIONS OR TESTS CONDUCTED WILL BE CAREFULLY PERFORMED BUT MAY BE UNCOMFORTABLE. CHIROPRACTIC CARE CENTRALLY INVOLVES WHAT IS KNOWN AS A CHIROPRACTIC ADJUSTMENT. THERE MAY BE ADDITIONAL SUPPORTIVE PROCEDURES OR RECOMMENDATIONS AS WELL. WHEN PROVIDING AN ADJUSTMENT, WE USE OUR HANDS OR AN INSTRUMENT TO REPOSITION ANATOMICAL STRUCTURES, SUCH AS VERTEBRAE. POTENTIAL BENEFITS OF AN ADJUSTMENT INCLUDE RESTORING NORMAL JOINT MOTION, REDUCING SWELLING AND INFLAMMATION IN A JOINT, REDUCING PAIN IN THE JOINT, AND IMPROVING NEUROLOGICAL FUNCTIONING AND OVERALL WELL-BEING.

IT IS IMPORTANT THAT YOU UNDERSTAND, AS WITH ALL HEALTH CARE APPROACHES, RESULTS ARE NOT GUARANTEED, AND THERE IS NO PROMISE TO CURE. AS WITH ALL TYPES OF HEALTH CARE INTERVENTIONS, 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, INCLUDING BUT NOT LIMITED TO HOT PACKS AND ICE, FRACTURES (BROKEN BONES), DISC INJURIES, STROKES, DISLOCATIONS, STRAINS, AND SPRAINS. WITH RESPECT TO STROKES, THERE IS A RARE BUT SERIOUS CONDITION KNOWN AS AN "ARTERIAL DISSECTION" THAT TYPICALLY IS CAUSED BY A TEAR IN THE INNER LAYER OF THE ARTERY THAT MAY CAUSE THE DEVELOPMENT OF A THROMBUS (CLOT) WITH THE POTENTIAL TO LEAD TO A STROKE. THE BEST AVAILABLE 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. PATIENTS WHO EXPERIENCE THIS CONDITION OFTEN, BUT NOT ALWAYS, PRESENT TO THEIR MEDICAL DOCTOR OR CHIROPRACTOR WITH NECK PAIN AND HEADACHE. UNFORTUNATELY A PERCENTAGE OF THESE PATIENTS WILL EXPERIENCE A STROKE.

THE REPORTED ASSOCIATION BETWEEN CHIROPRACTIC VISITS AND STROKE IS EXCEEDINGLY RARE AND IS ESTIMATED TO BE RELATED IN ONE IN ONE MILLION TO ONE IN TWO MILLION CERVICAL ADJUSTMENTS. FOR COMPARISON, THE INCIDENCE OF HOSPITAL ADMISSION ATTRIBUTED TO ASPIRIN USE FROM MAJOR GI EVENTS OF THE ENTIRE (UPPER AND LOWER) GI TRACT WAS 1219 EVENTS/ PER ONE MILLION PERSONS/YEAR AND RISK OF DEATH HAS BEEN ESTIMATED AS 104 PER ONE MILLION USERS.

IT IS ALSO IMPORTANT THAT YOU UNDERSTAND THERE ARE TREATMENT OPTIONS AVAILABLE FOR YOUR CONDITION OTHER THAN CHIROPRACTIC PROCEDURES. LIKELY, YOU HAVE TRIED MANY OF THESE APPROACHES ALREADY. THESE OPTIONS MAY INCLUDE, BUT ARE NOT LIMITED TO: SELF-ADMINISTERED CARE, OVER-THE-COUNTER PAIN RELIEVERS, PHYSICAL MEASURES AND REST, MEDICAL CARE WITH PRESCRIPTION DRUGS, PHYSICAL THERAPY, BRACING, INJECTIONS, AND SURGERY. LASTLY, YOU HAVE THE RIGHT TO A SECOND OPINION AND TO SECURE OTHER OPINIONS ABOUT YOUR CIRCUMSTANCES AND HEALTH CARE AS YOU SEE FIT.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE CONSENT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CHIROPRACTIC CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CHIROPRACTIC CARE FROM THIS OFFICE.

PATIENT NAME: _____ SIGNATURE: _____
DATE: _____

PARENT OR GUARDIAN: _____ SIGNATURE: _____ DATE: _____

WITNESS NAME: _____ SIGNATURE: _____ DATE: _____