# INFORMED CONSENT

There are inherent risks in every healthcare delivery system. Chiropractic healthcare is no exception. We want you to be informed of potential problems associated with chiropractic healthcare before consenting treatment. Chiropractic care has the least therapeutic risk of any care we know of. Chiropractic is a system of healthcare delivery. Therefore, as with any health care, we cannot promise a cure of any symptoms, disease, or condition as a result of treatment in this office. We will always provide you with our best care, and if results are sub optimal, we will refer you to another provider who will assist your situation.

Chiropractic manipulation/adjustments consist of the moving of bones, joints, muscles, ligaments and nerves, with the use of the doctor's hands or with the use of it tool. Frequently, the maneuvers are associated with a 'pop' or 'click' sounds and sensations in the area being treated. These are sounds of improvement. Very occasionally unexpected symptoms can occur.

**STROKE:** Stroke means a portion of the brain fails to receive enough oxygen via the blood vascular system. The results can be temporary or permanent, resulting in this function of the brain, with very rare complications of death. The vertebral arteries are found inside the neck vertebrae. The manipulation/adjustment commonly associated with federal artery stroke is called "extension rotation – thrust atlas adjustment". This type of manipulation/adjustment may also be potentially related to vertebral artery stroke, but there is no real certainty. The most recent studies estimate the incidence of this type of stroke in one per 3 million. This means the average chiropractic provider will practice hundreds of years before statistically associate with the stroke event.

**DISC HERNIATION**: Disc herniations that cause pressure on the spinal nerve or the spinal cord are frequently successfully treated with chiropractic care. Yet occasionally chiropractic treatment will aggravate a problem, rarely surgical intervention may be necessary in spite of chiropractic care. These events are so rare that no statistical literature is available to calculate probability.

**SOFT TISSUE**: Soft tissues refer primarily to muscle, muscle tendons, ligaments, blood vessels another tissues. Seldom a chiropractic manipulation/adjustment, traction, electric-muscle stimulation, massage therapy, etc., may irritate some muscle or ligament fiber. The result is a temporary increase in pain, but there is no long-term effect for the patient. These events are so rare that no statistical literature is available to calculate probability.

**PHYSICAL THERAPY BURNS: S**ome of the therapy machines we use generate heat. Both heat and ice are used in office and are frequently recommended for home use. Everyone's skin sensitivity is different, and rarely either heat or ice can burn or irritate the skin. This could result in temporary pain and possible blistering of the skin. These events are so rare that no statistical literature is available to calculate probability.

**SORENESS:** It is common for chiropractic manipulation/adjustment and some therapies, massage, traction, exercise, etc., to cause temporary increase in soreness in the region treated. This is nearly always a temporary and brief symptoms while your body is undergoing therapy to change. It is not dangerous, but please advise your doctor. Presence of a bruise is possible and more likely if patient takes blood thinners*

**MEDICATIONS:** *Are you taking any blood thinners? **Yes _____ No_____ Initial_____**

**OTHER PROBLEMS:** Other problems or complications may arise from chiropractic treatment. These other problems are so rare that it's not possible to anticipate or explain them to advance of treatment.

**COMPLICATIONS:** Patience with an an Aortic Aneurysm are at risk and need to advise the doctor and staff if you have one. **Yes _____ No_____ Initial_____**

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

**Print Name : _____ Date: _____**

**Signature : _____**

**Accident & Sports Injury Clinic**
Pamala Mitchell, D.C.
7623 Tezel Road San Antonio, TX 78250
(210) 680-5133 FAX: (210) 520-0891

# RELEASE OF MEDICAL RECORDS

PATIENT NAME: _____

PATIENT DOB: _____

MEDICAL FACILITY: _____

- ☐ X-Ray Reports
- ☐ X-Rays & Reports
- ☐ All Medical Records
- ☐ MRI Reports
- ☐ MRI & Reports
- ☐ CT Reports
- ☐ CT & Reports
- ☐ Doctor's Reports
- ☐ Laboratory Testing
- ☐ All Medical Record pertaining to injuries sustained on: ____/____/____.
- ☐ Medical information you deem would be helpful in the treatment of this patient.
- ☐ Medical records from other sources that meet the criteria checked above.

I, _____, hereby authorize and request medical information to be furnished to the following doctor: Pamala Mitchell, D.C.

_____ _____

Signature of Patient Date

## ASSIGNMENT AND AUTHORIZATION

## FOR DIRECT PAYMENTS BY MY PAYERS TO

## Pamala Mitchell, D.C. - ACCIDENT & SPORTS INJURY CLINIC

Purpose. The purpose of this assignment is to assist the Office in obtaining Proceeds from various Payers for the payment of my Charges. Accordingly, I agree to the following and direct all players as follows:

Definitions. In this assignment, the following terms shall have the following meaning: "Office" and "Clinic" shall refer to ACCIDENT & SPORTS INJURY located at 7623 TEZEL ROAD, SAN ANTONIO, TX 78250. "Payer" shall refer to without limit any insurance carrier, health benefit plan administrator and fiduciary, health maintenance organization, preferred and independent provider organization, and any other entity, which may elect or be obligated to pay or disbursed Proceeds, "Proceeds" shall include without limit, the proceeds from any promise to pay or reimburse, the proceeds relating to "health – care – insurance receivables" as such are defined by the applicable Uniform Commercial Code, and the proceeds relating to the following benefits, plans, or coverages: individual and group health benefits, Medicare and Medicaid, "Charges" shall include without limit the full fees for the Office's goods and services (including without limit treatment, diagnostic services, medical equipment, supplies, supplements, no narrative reports, photocopies, pre-authorization request, no-shows, depositions, and testimony,weather rendered before or after the date of this assignment, any collection cost incurred by the Office, delinquency penalties and interest to the maximum extent permitted under law or at the annual rate of 18%), whichever is greater, and any other charges incurred by me at the Office; "Collection Costs" shall include without limit any pre- and post judgment court costs, filing fees, service of process charges, attorneys fees, fees or costs associated with a request for reconsideration, independent reviews, appeals, mediation, arbitration, and any other costs of collection incurred by the Office in any effort or action to collect my charges either from me or from any Payer.

Assignment Terms. I hereby assigned to the Office to the extent permitted by law, but only to the extent of my charges, all of my claims to, rides to and interest in, Proceeds, whether resolved or on result, including without limit ownership rights, which I may have now or in the future relating directly or in directly to my Charges, condition, or causes of my condition ("Claims to Proceeds"), including without limit any and all causes of action, receivables, payment intangibles, and remedies that I might have against or with respect to any Payor now or in the future, and the right to prosecute, seek, settle, or otherwise resolve such claims to Proceeds either in my name or in the Office's name and as the office otherwise sees fit. I agree that this assignment shall be effective as of the date and time the initial cost of my condition occurred. I further intend for this assignment to create a security interest under the applicable Uniform Commercial Code. Accordingly, I hereby grant to the Office a primary, non- contingent security interest in all of my Claims to Proceeds to the extent permitted by law for the purpose of securing payment of my Charges, the attachment and perfection of which shall relate back to, and be effective as of, the date and time that the initial cost of my condition occurred. I further authorize the Office to file the form (s) normally filed with the Secretary of State or other governmental agency relating to such security interests, and to make such filings in all relevant jurisdictions as the Offices sees fit in its sole discretion. I agreed that once payment in-full has been made towards all outstanding Charges to the full extent permitted by law or contract and also as defined by my agreement with the Office, such security interest shall be removed or terminated solely upon my written request sent through the U.S. Postal Service Certified Mail. Consistent with these terms, I hereby direct any and all Payers, to pay the Proceeds directly to, immediately to, and exclusively in the name of, the Office to the full extent of my Charges.

Disclosure Directives. I hereby direct each and every Payer to immediately release to the Office any Pertinent Information relating to (a) any coverage I may have and (b) any Proceeds Determination by the payer relating to the Office's Charges. "Pertinent Information" shall include without limit copies of all documents, records, and other information (a) relied upon by the Payer in making a Proceeds Determination, or (b) was submitted, considered, or generated in the course of making a Proceeds Determination without regard to whether such document, record, or other information was relied Upon in making the Proceeds Determination. "Proceeds Determination" shall include without limit any determination by the Payer to pay, deny, or delay payment of any Proceeds relating to the Office's Charges, as well as a decision to refer the charges to an independent review or audit, utilization review, or independent medical exam. I further authorize and direct the Office to release any information relating any services rendered to or for me by the Office to all Payers, including without limit a copy of my Charges and a copy of this Assignment, unless otherwise agreed to in writing.

Miscellaneous. Except as provided in this paragraph, this Assignment shall not be modified or revoked without the expressed, written consent of the Office. I hereby revoke, with the Office's consent the terms of any previously signed documents, but only to the extent of those terms conflict with the terms of this Assignment. I agree that each and every provision of this Assignment is reasonably necessary. However, should any provision of this Assignment be found to be invalid, illegal or unenforceable, or for any reason ceases to be binding on any party hereto, all other portions and provisions of this Assignment shall, nevertheless, remain in full force and effect. This Assignment shall be governed under the laws of the state where the Office is located, and is performable in the county where the Office is located. In any action based upon this agreement, I hereby consent a personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum inconvenience. I further waive any statute of limitations which may apply in any action based upon this Assignment.

I have read, understood, and agreed to the terms of this Assignment.

Patient Name (print) : _____

Patient Signature : _____ Date: ___/___/___

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (please print) : _____

Parent/Guardian Signature: _____ Date: ___/___/___

# OFFICE POLICIES

To help you receive our best, ALL patients are accepted for care based on the following policies.

## REFERRALS:

The greatest honor a patient can give to their doctor is the referral of their family and friends.

We promise to give your loved ones the same quality, love and attention that you receive. Thank you in advance.

## OFFICE HOURS:

Your questions are always welcome, however consults (or questions) may require scheduling.

Hours of Operations are:

Tuesday, Thursday: 10:30 AM - 6:30 PM*

Wednesday, Friday: 9:00 AM - 5:30 PM*

*Lunch taken at 12:30 - 2:00 PM with last appointment before lunch scheduled at 11:30 am.

## APPOINTMENT SCHEDULING:

To save time, we ask that you schedule all your appointments in advance. Please refrain from repeatedly rescheduling appointments within a 24 hour period. We reserve the right to reschedule your appointment if you arrive more than 15 minutes late.

## MISSED/BROKEN APPOINTMENT FEE:

Our goal is to provide quality care to all our patients and when appointments are missed without notice it effects your care, staffing, and compromises our ability to schedule other patients.

**Fee: $25.00,** if you fail to notify us 24 hours in advance of your scheduled appointment.

## FINANCIAL AGREEMENTS:

It is your payment that allows us to continue providing high levels of professional care, maintain our facility, and pay our staff. As a courtesy, payment arrangements may be made at the discretion of the doctor. If for any reason, you are unable to keep your financial agreement, inform us immediately to eliminate any misunderstandings. If you have the desire to receive care in our office, we will make every attempt to make affordable arrangements.

## TERMINATING YOUR CARE:

In the event you choose to discontinue your care for any reason, or we regretfully find it necessary to discharge you from our care, any outstanding fees become payable and due immediately.

## OCCASIONALLY:

It is necessary for Dr. Mitchell to be away from the office for conferences, continuing education seminars, or vacations.

## DISCOURAGEMENT:

Remember that healing and spinal correction takes time. If any time during your care, you do not feel that you are responding as well as you expected, please discuss it immediately with the doctor. We want you to get the most from your chiropractic care!

## CONTACT:

Our office may periodically contact you by **phone, mail, email**, or **text** in regards to:

☑ Special Promotions/Events

☑ Birthdays

☑ Appointments

I have read and hereby accept the above policies.

_____ _____ Date: ___/___/_____

Patient's Name Printed Patient Signature

_____ _____

Guardian's Name Printed Guardian's Signature

Oct. 2018

PAMALA A. MITCHELL, D.C.
**ACCIDENT & SPORTS INJURY CLINIC**
7623 TEZEL ROAD
SAN ANTONIO, TEXAS 78250
(210) 680-5133

# PATIENT'S STATEMENT OF PRIVACY RIGHTS

As a patient of this practice, you have the right to privacy of you Personal Health Information, and to know that such information shall be properly ad securely maintained by this practice, I accordance with our own policy and in compliance with the Health Information Accountability and Portability Act of 1996 (HIPAA). HIPAA was enacted to give you, the patient of a health care provider and covered under a health insurance claim, more control over your health information, to set boundaries on the use and release of health records, establish appropriate safeguards that health care providers ad other must achieve to protect the privacy of Personal Health Information, and to hold violators accountable penalties for violation of a patient's right to privacy.

AS A PATIENT OF THIS PRACTICE: (You are entitled to or You have the right to)

1. An individually delivered, written notification of your Privacy Rights at the time of your first visit to this practice's facility. **(The document you are reading is this notice.)**

2. a. Make amendment to your Patient Health Information within those records. (Forms available upon request.) b. While the doctor has a right to deny inclusion of amendments into a patient file, you have the right to disagree with the doctor's refusal of such inclusion of amendment to those records. (Forms available upon request.) If the doctor disagrees, she shall supply you with written notification of such disagreement. c. The doctor has a right to a rebuttal to the patient's disagreement. A copy of that rebuttal must be included in the file any time the file is sent out of the office.

3. See your medical records or receive a copy of your medical records. (Medical records are available upon request.) As per allowance by HIPAA the charge will be 25 cents per page.

4. a. To specify how assess to your Health information is restricted and from whom. b. To indicate the method and /or phone numbers and/or addresses to which telephonic and written communications to you shall be forwarded. c. That no personal health information shall be given out to any entity not related to your treatment and the billing of medical services rendered, without written authorization. d. This practice's best effort to maintain the security of Personal Health Information on your behalf within and outside this office. e. That this practice shall provide Personal Information to required parties on the basis of the minimum necessary standard of release (releasing only that information necessary for those parties to provide treatment, reimbursement , or administrative services on your behalf), and so as to maintain the intent of HIPAA in establishing standard.

5. That all other covered entities under HIPAA, such as this practice or other health care providers, or business associates such as billing companies or claims administrators, as are designated by the HIPAA Privacy Rule, and with whom this practice must work on your behalf from the standpoint of effective treatment or billing of medical services and administration of such services, shall be part of a "chain of trust" under applicable Business Associated Agreements whenever applicable with those parties. This means that those parties are bound to maintain the same privacy and security of your health information, as are we.

6. Inquire of this office and gain correct and appropriate answers to any questions regarding your privacy rights at any time, consistent with those rights as covered by HIPAA.

7. Contact the Department of Health and Human Services, Office of Civil Rights, which administrates HIPAA, with questions or to file a complaint at, Toll Free: 1 - (877) 696 - 6775 or email: www.hhs/gov/ocr

NOTE: This clinic has an open environment, such as your conversations with staff, the doctor, other health care providers, or business associates such as billing may be less than private. Please request any questions or conversation that you deem private be had in the available more private areas of the clinic.

*PATIENT'S AFFIRMATION OF RECEIPT OF PATIENT'S STATEMENT OF PRIVACY RIGHTS*
*I hereby acknowledge receipt of this office's Statement of Privacy Rights, provided on my behalf and in accordance with law, and have read and understand my rights to privacy and security of Personal Health Information, as a patient of this practice.*

| Patient's Name Printed | Patient's Signature | Date |
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