Request for Alternative Communications

Daniels Chiropractic Inc.

Patient Name: _____

Address: _____

Date of Birth: _____ Date of Request:_____

As allowed by the Privacy Regulations I wish for this office to provide the following alternative means of communicating my Protected Health Information:

☐ Mailing Address:

If appropriate, please contact me at the following address:

_____

☐ Phone: If appropriate, please contact me by telephone at the following number:

_____

☐ Email: If appropriate, please contact me at the following e-mail address:

☐ Fax: If appropriate, please contact me by fax at the following number: _____

☐ I have the following additional requests for confidential communications regarding my Protected Health Information: please explain:_____

_____

_____

☐ I understand that there may additional costs associated with this request and I agree to reimburse this office for such costs.

_____

Signature: _____ Date:_____

☐ Accepted as requested Modified as noted: _____

Authorized Signature of Facility _____ Date:_____

Pamela Daniels, DC, CCSP, DACNB, FABBIR
1165 Park Avenue
San Jose, CA 95126
(408) 292-9765

Chiropractic Consent Form

To our Patients: Please read this entire document prior to signing it. It is important that you understand the information contained in the document. Please ask questions before you sign if there is anything that is unclear.

Medical doctors, chiropractic doctors, osteopaths, and physical therapists that perform manipulation are required by law to obtain informed consent before starting treatment.

I, _____ consent to examination and to the performance of conservative noninvasive treatments for my condition. I understand that the procedures may consist of manipulations involving movement of my joints and soft tissues, along with physical therapy modalities and rehabilitative exercises. Therapeutic modalities could include, but are not limited to: Spinal manipulative therapy, range of motion testing, muscle strength testing, palpation, myofascial release, orthopedic testing, postural analysis, hot/cold therapy, vital signs, basic neurological testing, and electrical muscle stimulation.

I do not expect the doctor to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon all factors known, and is in my best interest. I intend this consent form to cover the entire course of treatment for my present condition, and for any future conditions for which I seek treatment.

Although spinal and extremity manipulation is considered to be one of the safest and most effective forms of therapy for musculoskeletal problems, I am aware that, as with any form of therapy, there are possible risks and complications associated with these procedures, which include but are not limited to:

Initial _____ **Soreness**: I am aware that like exercise, it is common to experience muscle soreness after a few treatments.

Initial _____ **Dizziness**: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Initial _____ **Joint injuries**: I understand that in isolated cases, underlying physical defects, deformities of pathologies like weak bones from osteoporosis may render that patient susceptible to injury. When osteoporosis discal degeneration or other abnormality is detected, extra caution will be employed such as non force techniques.

Initial _____ **Physical therapy burns**: Some of the therapies used in this office generate heat and may rarely cause burns. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor.

Initial _____ **Strokes**: Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Although strokes occasionally occur in our world, strokes from chiropractic manipulations are extremely rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments, the same chance as being struck by lightning or having a normal dose of Tylenol cause death.

Initial _____ **Other possible complications**: Fractures, disc, injuries, dislocations, muscle strain, cervical myelopathy, and costovertebral stress.

Pamela Daniels, DC, CCSP, DACNB, FABBIR
1165 Park Avenue
San Jose, CA 95126
(408) 292-9765

Tests have been performed on me prior to treatments to minimize the risks of these or any other complications from treatment, and I freely assume these risks. I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, reduced muscle spasm, increased mobility, and improved neurological function. However, I appreciate that there is no certainty that I will achieve these benefits. I realize that the practice of all forms of medicine, including chiropractic, is not an exact science, and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

The availability and nature of other treatment options:

Other treatment options for your condition may include: Self administered, over the counter analgesics and rest, Medical care and prescription drugs such as anti=inflammatory, muscle relaxants and painkillers, hospitalization, or surgery.

If you chose to use one of the above noted "other treatment" options you should be aware that there are risks and benefits of such options and you may with to discuss these with your primary medical physician.

I have read, [ ] or had read to me, [ ] the explanation of chiropractic treatment. Any questions I have regarding these procedures or alternative treatments available have been answered to my satisfaction prior to my signing this consent form. I have made my decision voluntarily and freely.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

Signature of Patient: _____

Signature of legal guardian for minor: _____

Signature of witness: _____

Signature of Doctor: _____

Date: _____

Graston Technique® Questionnaire and Informed Consent

Please answer the following questions. Read the statements concerning Graston Technique®, and sign below. If you have any questions, please speak with your clinician.

1. Do you bruise easily? Yes No
2. Do you bleed for a long period of time after you cut yourself? Yes No
3. Are you taking blood thinners or anticoagulants? Yes No
4. Do you take aspirin on a regular basis? Yes No
5. Do you take cortisone on a regular basis? Yes No
6. Have you ever had inflamed veins or blood clots? Yes No
7. Do you have surgical implants in your body? Yes No
8. Do you have diabetes or kidney disease? Yes No
9. Do you currently have any infections? Yes No
10. Do you have uncontrolled high blood pressure? Yes No

Graston Technique® (GT) is an instrument assisted variation of traditional cross fiber or transverse friction massage. The GT instruments consist of six stainless steel tools of various sizes and contours. GT is a form of treatment used to "break up" or "soften" scar tissue, thus allowing for the return of normal function in the area being treated.

Graston Technique® may produce the following:

1. Local discomfort during the treatment.
2. Reddening of the skin.
3. Superficial tissue bruising.
4. Post treatment soreness.

Graston Technique® is designed to minimize discomfort; however the above reactions are normal, and in some instances unavoidable.

Graston Technique® has several basic components. Your clinician will determine the protocol for you.

1. Warm up of the treatment area.
2. Graston Technique Instrument Assisted Soft-Tissue Manipulation.
3. High repetition, low load exercise.
4. One to three 30-second stretches.
5. Low repetition, high weight exercise.
6. Ice therapy.
7. Stretching/rehabilitation exercise.

All components of Graston Technique® have been explained to me. I understand the risks of the procedure and I give my full consent for treatment.

Print your name_____ Date_____

Your signature_____

PATIENT APPOINTMENT AGREEMENT AND FEE SCHEDULE

It is essential to maintain your set appointment dates. This maintains optimal treatment for your health and spine.

Our fees are as follows:

1.	Initial Exam:	$320 (additional fees may apply)
2.	30 min visit:	$150 minimum
3.	45 min visit:	$225 minimum
4.	60 min visit:	$300 minimum
5.	Missed Appt Fees:	$50-150

This fee schedule is effective January 1, 2020 and is subject to change.

In order for our Doctors to adequately evaluate and treat our patients they must have adequate time with their patients. It is extremely important for all patients to arrive in our office **15 minutes prior to their scheduled appointment time.** This allows time for paperwork to be filled out with an update, to be placed on the table, and for the doctor to have the appropriate time to evaluate you. The time of the appointment, is the time the patient should be on the table. Appointments are reserved especially for you; we do not double book appointments. As a courtesy to other patients we ask that you respect our office policy.

The office policy of Transformations is to charge a missed appointment fee if a patient is more than 10 minutes late for an appointment,

Missed appointment fees are:
$ 50 for a 30 minute appointment
$ 100 for an hour appointment
$ 150 for New Patient appointment

Appointments **must** be cancelled at least 2 business days prior to the scheduled appointment time. Any appointments canceled with less than a 2 business day notice will result in a missed appointment fee. New Patient appointments require a 7 day notice.

Signature: _____ Date: _____

NOTICE OF PATIENT'S FINANCIAL LIABILITY

Transformations: A Chiropractic Studio

I, _____, hereby acknowledge, understand, and agree that I am financially responsible for payment of all services and/or goods received from Transformations. Transformations is not contracted with insurance companies including automobile med pay insurance, however, as a courtesy to the patient, Transformations MAY elect to verify and bill my insurance carrier/med pay. Transformations is under NO OBLIGATION WHATSOEVER to perform this courtesy, however. Further, in the event that Transformations does verify and/or bill my insurance carrier/med pay, I, _____, hereby acknowledge, understand, and agree that this courtesy in no way discharges or diminishes my financial liability for any and all services and/or goods received from Transformations. I, _____, acknowledge, understand, and agree that if Transformations elects to perform a courtesy billing of my insurance carrier/med pay, it remains my responsibility to pay for all invoiced services and/or goods received from Transformations if my insurance carrier/med pay fails to pay such invoiced services and/or goods, without offset, within 30 days of submittal to said insurance carrier/med pay. Co-payments are due at the time of the appointment.

Please keep in mind that your insurance is a contract between you and your insurance carrier/med pay. Transformations is not responsible for erroneous information given to us by you or your insurance company. If at any time your insurance carrier/med pay discontinues coverage or denies payment on your account you will be responsible for all incurred charges.

By signing below, I hereby indicate my acknowledgement, understanding, and agreement with these terms:

_____ _____

Patient's Printed Name Patient's Signature

_____

Date

_____ _____

Witness' Printed Name Witness' Signature

_____

Date