performancehealth
SPINE & SPORT THERAPY

Informed Consent to Chiropractic, Physical Therapy, and Soft Tissue Care

I hereby request and consent to the performance of Chiropractic Adjustments and other Chiropractic procedures, including various modes of manual/physical therapy (Active Release Techniques, Therapeutic Stretching, Massage, Therapeutic Ultrasound, Electric Muscle Stimulation, Cold Laser Therapy, Graston, and hot or cold packs), upon myself by Dr. Brett Coapland, Dr. Kanoa King, Dr. Sarah Coulombe, Dr. Ross Childs, or other associates, and/or other office or clinic personnel.

I further understand and am informed that, as in all health care, in the practice of Chiropractic, there are some very slight risks to treatment, including but not limited to the following:

- Rare cases of rib fracture, muscle and ligament sprains or strains following manual adjustments
- There have been reported cases of injury to a vertebral artery following cervical spinal adjustments. Vertebral artery injuries have been know to cause stroke, sometimes with serious neurological impairment and may on rare occasion result in serious injury. The possibility of such injuries resulting from cervical spinal adjustment is extremely remote.
- There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustments.

I do not expect the doctor to be able 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 the facts known, and is in my best interest. Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies, conducted over many years and has been demonstrated to be a highly effective treatment for back pain and musculoskeletal pain.

Print Patient's name	Patient's (or Guardian's) Signature	Date

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Authorization and Assignment

In consideration of treatment, I agree to the following:

- I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Performance Health all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Performance Health to release all necessary information to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.
- I authorize direct payment to Performance Health Spine & Sport Therapy ("Performance Health") of any sum I now or hereafter owe to Performance Health by my attorney out of the proceeds of any settlement to my case, and by any insurance company obligated to make payment to me or Performance Health based in whole or in part upon the charges made for your services.
- It is understood that my insurance contract is between myself, and my insurance carrier, and there is no guarantee of insurance payment. The office of Performance Health and its assigns will make all efforts to obtain payment, but will not enter into a dispute with the carrier/insurer.
- In the event any insurance company, obligated by contractual agreement to make payment to me or to Performance Health for the charges made for their services, refuses to make such payment upon demand by them, I hereby assign and transfer to them the cause of action that exists in my favor against any such company and authorize them to settle or compromise as they see fit. I understand that whatever amounts you do not collect from the insurance company, whether it is all or part of what is due, I personally owe.
- The office of Performance Health and its assigns will file claims for all dates of service. State law requires all applicable coinsurance and co-payments be collected at the time of service and any further monies owed, including deductibles, will be billed to me.
- I have been offered a copy of the HIPAA Disclosure of Protected Health Information notice.
- I understand that if I miss an appointment, I will be charged a fee, equal to the missed visit charges, which must be paid prior to receiving treatment or scheduling another visit. I understand there is a **24-hour cancellation policy** in which if I need to cancel or reschedule an appointment, I will do so at a minimum of 24 hours prior to my appointment or I will be charged a fee.

_____

Print Patient's name Patient's (or Guardian's) Signature Date

Statement of Understanding

I agree that I have read and understand the Informed Consent to Chiropractic and Soft Tissue Care, Physical Therapy, and Authorization and Assignment as stated above. I therefore intend the above-signed consents to apply to all my present and future Chiropractic care with Dr. Coapland, Dr. King, Dr. Coulombe, Dr. Childs, and other associates at this or other clinic locations, sporting, or other media events.

_____

Print Patient's name Patient's (or Guardian's) Signature Date