

Notice of Privacy Practices

The privacy of your medical information is important to us, and we are committed to protecting it. This notice describes how information about you may be used and disclosed, as well as, how you can get access to this information. Please read carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations. These include emergency care, quality assurance activities, payment, public health, research and law enforcement activities. Any other disclosure for purposes of treatment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days of a written request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

In the future we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change our privacy practices and the terms of this notice any time, provided that the changes are permitted by the law. We have the right to make changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including previously created or received before the changes.

If you have any questions about this notice or if you think that we may have violated you privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the information to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

Office of Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509 F HHH Building
Washington, DC 20201

Contact Person: Dr. Mehal Patel
17 E. Northwest Highway Suite 4
Palatine, IL 60067

I, _____ Hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed: _____ Date: _____

Financial Obligations

I clearly understand and agree that all services to me are my responsibility. I understand that if I elect to use my insurance that some services are not covered and are my personal responsibility. I also understand that fees for professional services, products, and shipping charges rendered to me will be immediately due and payable. If there is any unpaid balance on my account at any time, it will be billed to me if no other arrangements have been agreed upon. In the event that there still remains an unpaid balance on my account after being billed, I clearly understand that Back2Spine Chiropractic elect to turn the issue over to a collection agency and/or take legal actions.

I, _____ have read and clearly understand everything above.

Signature: _____ Date: _____

Optional Authorization

If you wish to elect that all unpaid balances be automatically charged to your credit card, please provide information below:

Patients Name: _____

Card Holders Name: _____

Card Type & Number: _____

Expiration Date: _____

3 or 4 Digit Security Code (on back of card): _____

Billing Address: _____

Billing Zip Code: _____

I authorize Back2Spine Chiropractic to debit my credit card listed above.

Signature: _____ Date: _____

Office Policies

It is required that you call the office to reschedule or cancel your appointment. Any missed appointments will be charged \$25.00. We understand that at times things can slip our minds and we allow each patient 1 and only 1 missed appointment at no penalty. If you do need to reschedule please give us a 24 hour notice so that we can make arrangements to our appointment sheet.

It is required that all patients adhere to the recommended treatment plan prescribed by the doctor. Multiple visits are often necessary in order to establish integrity and create plasticity as well as to maintain your health.

Re-evaluation and Progress exams let the doctor know if the trial of care is going in the appropriate direction. These are required and because of the extra time spent and medical decision making required to re-evaluate your status, this is a charged exam. Although it is not as intense or as long in duration as the initial evaluation it is just as important to keep us on track to getting you to a better state of health.

We ask that you maintain proper language (no foul, offensive or curse words) and respect to our staff and other patients. Please refrain from speaking loudly in the waiting room on a cell phone. We have some patients that suffer with migraines among other things that loud noise can further irritate.

If you have any questions or comments regarding our office policies please place them below and let our front desk staff know.

Thank you.

Signature_____

Date:_____

Consent to Treatment

Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment.

There are some risks that may be associated with treatment, in particular you should note:

- a. While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment.
- b. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustments although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal or soft tissue manipulation or treatment.
- c. There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely remote.

Osseous and soft tissue manipulation has been the subject of government reports and multi-disciplinary studies conducted over many years and have been demonstrated it to be a highly effective treatment of spinal conditions including general pain and loss of mobility, headaches and other related symptoms. Musculoskeletal care contributes to your overall well-being. **The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.**

I acknowledge I have discussed the following with my healthcare provider:

- a. The condition that the treatment is to address
- b. The nature of the treatment
- c. The risks and benefits of that treatment, and
- d. Any alternatives to that treatment

I have had the opportunity to ask questions and receive answers regarding the treatment.

I consent to the treatments offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intend this consent to apply to all my present and future care with _____ (healthcare providers name).

Dated: This _____ day of _____ 20 _____

Patient Signature (or Legal Guardian)

Signature of Witness

Print Name: _____

Print Name: _____