

INFORMED CONSENT

Patient Name _____

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

The nature of the chiropractic adjustment:

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to restore function to your joints. **That** may cause an audible "pop" or "click" much as you have experienced when you "crack" your knuckles. You may feel a sense of movement. I also use other techniques that do *not* cause an audible "pop" or "click".

Analysis / examination / treatment:

As a part of the analysis, examination, and treatment, you are consenting to one or more of the following procedures:

- | | | |
|-----------------------------|--------------------|------------------------------|
| spinal manipulative therapy | palpitation | vital signs |
| range of motion testing | orthopedic testing | basic neurological testing |
| muscle strength testing | postural analysis | ultrasound |
| hot/cold therapy | EMS | radiographic studies (x-ray) |
| other _____ | | |

The material risks inherent in chiropractic adjustment:

As with any healthcare procedure, there are certain complications which may (in the most extreme rare circumstance) arise during chiropractic manipulation and therapy. These complications may include but are not limited to: fractures, disc injuries, dislocations, muscle strain, costovertebral strains and separations, cervical myelopathy and burns. 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. None of these risks have ever occurred to any patient, as a result of, or during the course of treatment by Dr. Glen Thornton. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contradictions to care; however, if you have any condition that would otherwise not come to my attention, it is your responsibility to inform me.

The possibility of those risks occurring:

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history, examination and x-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare. The other complications are also generally described as rare. Again, none of these risks have ever occurred to any patient, as a result of, or during the course of treatment by Dr. Glen Thornton.

The availability and nature of other treatment options:

Other treatment options for your condition may include:

- *Self-administered, over-the-counter analgesics
- *Medical care and prescription drugs such as anti-inflammatory medication, muscle relaxants and pain-killers.
- *Hospitalization
- *Surgery
- "Rest

If you choose 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 wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated:

Remaining untreated may allow the formation of adhesions and reduced mobility which may set up pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

Please check the appropriate block and sign below.

I have read [] or have had read to me [] the above explanation of the chiropractic adjustment and related treatment. If I have questions, I will discuss them with Dr. Thornton. By signing below, I state **that** I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to **that** treatment.

Dated: _____

Dated: _____

Patients name (print)

Dr. Glen Thornton, D.C.

Doctor's Name

Signature

Signature

Signature of parent or guardian (if a minor)

THORNTON CHIROPRACTIC CENTER

906 Lithia Pinecrest Road
Brandon, FL 33511
813/685-7107

FINANCIAL ARRANGEMENT POLICIES

_____ Private Pay: Any private pay account must be paid in full after each appointment. Medicare:

_____ We will file directly for payment with the Medicare carrier.

_____ **Health Insurance:** if you are covered under a health insurance policy that covers chiropractic care, we will file directly for payment from your insurance carrier. After verbal verification of your coverage, you will be personally responsible to pay that portion not covered by your insurance plus any deductible that has not been met. *See Authorization for all Insurance Patients Form.*

_____ **Automobile Insurance:** If you have been in an automobile accident and wish us to file our bill with your automobile insurance, we will do so with an assignment of benefits. You however, agree to pay any applicable deductible or co-payment not covered by the PIP or other coverage. *See Assignment of Benefits/Policy Rights Form.*

Attorney Representation: We will request a letter of protection from your attorney after your first visit with our office. This letter must be signed by you.

All Patients: We charge interest on unpaid balances. This charge is 1.5% monthly or 18% annually.

All Patients: We charge \$35.00 for a missed appointment. If we are not notified within 24 hours of your scheduled appointment time, your account can be charged

I have read, initialed and fully understand and agree to abide by the arrangements and policies that pertain to me. I furthermore acknowledge and agree that I am responsible for paying Dr. Glen Thornton's fees for treating me. Payment is due on demand.

ALL PATIENTS: IF YOUR ACCOUNT IS TURNED OVER TO A COLLECTION AGENCY, YOU ARE RESPONSIBLE FOR COLLECTION AGENCY FEES, AS WELL AS INTEREST AND REASONABLE ATTORNEY FEES.

Print Name _____ Date _____

Signature _____



Understanding Health Information Privacy

The HIPAA Privacy Rule provides federal protections for personal health information held by covered entities and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of personal health information needed for patient care and other important purposes.

The Security Rule specifies a series of administrative, physical, and technical safeguards for covered entities to use to assure the confidentiality, integrity, and availability of electronic protected health information.

Revised date 5/28/2013

PATIENT RIGHTS AND RESPONSIBILITIES

Healthcare Providers have a responsibility to give the patient a general understanding of the procedures to be performed and to provide information pertaining to their health care, so that the patient may make decisions in an informed manner after considering the information related to their condition, the available treatment alternatives, and substantial risks and hazards inherent in the treatments.

A PATIENT HAS THE RIGHT:

- To be treated with courtesy and respect, with appreciation of his individual dignity, and with protection of his *need* for privacy.
- To a prompt and reasonable response to questions and requests.
- To choose a personal attending physician and to know who is providing medical services and who is responsible for his/her care.
- To know what rules and regulations apply to his/her conduct.
- To be given by his/her health care provider (physician) information concerning diagnosis, planned course of treatment, alternatives, risks and prognosis
- To refuse treatment, except as otherwise provided by law.
- To be given, upon request, full information and necessary counseling on the availability of known financial resources for his care.
If eligible for Medicare, to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- To receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- To receive a copy of a reasonably clear and understandable itemized bill, and upon request, to have charges explained.
- To impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
To treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- To know if medical treatment is *for* the purpose of experimental research and to give his consent or refusal to participate in such experimental research.
- To express grievances regarding any violation of his/her rights, as stated in Florida Law, through the grievance procedure of the health care provider or healthcare facility, which served him/her and to the appropriate state licensing agency.
- To have a family member or representative of his/her choice as *well* as physician notified promptly of admission to the hospital.
- To have appropriate assessment and management of pain.
- To access the information contained in his/her clinical record within a reasonable time frame.
- To be free from all forms of abuse or harassment.
- To be free from restraints of any form that are not medically necessary.

A patient shall have a general understanding of their responsibilities to their healthcare provider and healthcare *facility*. It is hoped that *by* providing this information to *the* patient, that potential misunderstanding of their responsibilities will be eliminated. Florida public policy states that the interests of each patient be recognized, and that a healthcare facility or healthcare provider may not require a patient to waive this as a condition of treatment.

THE PATIENT IS RESPONSIBLE:

- For providing to the health care provider, to the best of his/her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations., medications and other matters relating to his/her health.
- For reporting unexpected changes in his condition to his/her health care provider.
- For reporting to his health care provider whether he/she comprehends a contemplated course of action and what is expected of him/her.
- For following the treatment plan recommended by the health care provider.
- For keeping appointments and, when he/she is unable to do so for any reason, for notifying the health care provider or health care facility.
- For his/her actions if he/she refuses treatment or does not follow the health care provider's instructions.
- For assuring that the financial obligations of his/her health care are fulfilled as promptly as possible.
- For following health care facility rules and regulations affecting patient care and conduct.

HIPAA PRIVACY: KEYS TO SUCCESS

What is HIPAA?

HIPAA is the Health Insurance Portability and Accountability Act of 1996, a Federal Law, which is mandatory; and there are penalties for failure to comply with it. Its purpose is to:

- Protect health insurance coverage, with improvement in access to healthcare
- Reduce fraud and abuse
- Improve quality of healthcare in general
- Reduce healthcare administrative costs (electronic transactions)

What is protected by HIPAA? PHI = Protective Health Information

- Name
- Address including street, city.
- County, zip code and equivalent
- Geocodes
- Names of relatives/employers
- Birthdate
- Telephone numbers/fax numbers
- Electronic e-mail addresses
- Social Security Number/Medical record number
- Health plan beneficiary number/account number
- Certificate /license number
- Vehicle or other device serial number
- Web universal locator (URL)
- Internet Protocol (IP) address number
- Finger or voice prints
- Photographic Images
- Any other unique identifying number, characteristic or code

How will HIPAA affect you?

- All faxes have cover-sheets with confidentiality statement
- Computer screens out of public view & screensavers in use
- Patient charts in secure areas
- PHI in Shred-It containers for disposal
- Patient passcode for family members
- Patient information accessed on need to know basis only
- "Notice of Privacy Practices" brochure to every patient at time of registration
- Patients may "opt out" of our directory
- Patients right for copy of medical record
- Patient authorization to release information for reasons other than for treatment or healthcare operations. Authorization is required for payment information to be released in the State of Florida

HIPAA Terminology

FPO: Facility Privacy Official

PHI: Protected Health Information

CE:	Covered Entity (Health plans, healthcare clearinghouses, and healthcare providers that transmit electronically for billing purposes, i.e. hospitals, physician practices, insurance companies, ambulance transportation services, hospice and home health)
OHCA:	Organized Health Care Arrangement (The hospital & medical staff will be considered an Organized Health Care Arrangement)
DRS:	Designated Record Set
AOD:	Accounting of Disclosure
Directory:	Census List w/ Name & Room #
TPO:	Treatment, Payment, Healthcare Operations

Facility Privacy Official

Our Facility Privacy Official is Cassie Smith, and she can be reached at extension 5259. Her responsibilities include:

- Privacy program
- Patient complaints
- Privacy rights of patients
- Requests for privacy restrictions
- Facilitate training and education of staff

Notice of Privacy Practices

Each patient will receive this notice upon each registration. It outlines patient rights to: access, amend, confidential communication, privacy restriction, and opt out of directory.

Sharing PHI

There are times when PHI is shared with others. We can share with other treatment providers:

- For reasons of treatment, payment or healthcare operations (TPO) and share with physicians and office staff, hospitals, or other treatment facilities

Other CE can request only the minimum necessary to perform their job and we may request from them only the minimum necessary to perform our job. Always verify the requestor according to policy: Requestors via phone will need: patient SS#, DOB, and one of the following:

- account number
- street address
- MR*
- birth certificate
- insurance card or policy number