

INFORMED CONSENT

Informed Consent to Chiropractic Examination and Treatment

I hereby request and consent to the performance of examination, chiropractic adjustments, manual therapy and any other procedures, including, but not limited to, diagnostic tests, blood testing, salivary testing, diagnostic x-ray(s), physical therapy techniques, and/or neurological therapy techniques on me, my child, or the person named below for which I am legally responsible, which are recommended by Dr. Charles M Sefcik, DC, DACNB, CCN and/or other licensed doctors of chiropractic who now, or in the future, render treatment to me while employed by, working for, associated with, or serving as an on-call doctor for Life Enhancement Clinic, P.C.

I understand that as with any healthcare procedure, there are certain complications, which may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains, and separations. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. This very rare event occurs during manipulation with the head in a rotated and extended position – a method of adjusting that is not used in this clinic. I do not expect the doctors to be able to anticipate all risks and complications and I wish to rely on them to exercise judgment during the course of the procedure(s), which they feel at that time, based upon the facts then known, are in my best interest.

- 1) I hereby authorize Life Enhancement Clinic, P.C. to examine and treat my conditions as they deem appropriate with chiropractic healthcare, and I give authority for performance of these procedures.
- 2) Life Enhancement Clinic, P.C. will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

I affirm that I am not currently pregnant or trying to become pregnant. Should this condition change, I will notify Dr. Charles M Sefcik and/or their staff as soon as possible.

Initials _____ Date of last menstrual period ____/____/____

I have read or I have had read to me the above explanation of the chiropractic adjustment and related treatments. By signing below, I state that I have weighed the risks involved in undergoing chiropractic care and have decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent for chiropractic treatment. I understand the results are not guaranteed.

I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I understand the information above and guarantee all forms were completed correctly and to the best of my knowledge. I further understand it is my responsibility to inform this office of any changes in my medical state.

_____/_____/_____
Patient Signature (or representative if minor or physically incapacitated) Date

Health Insurance Portability and Accountability Act (HIPAA)

Patient consent for use and/or disclosure of protected health information to carry out treatment, payment and health care operations.

I, (Print Name) _____, hereby state that by signing this Consent, I acknowledge and agree as follows:

- 1) The Privacy Notice includes a complete description of the uses and/or disclosures of my protected healthcare information (“PHI”) necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its healthcare operations. The Practice explained to me that the Privacy Notice would be available to me at any time in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice before signing this Consent, and has encouraged me to read the Privacy Notice carefully before my signing this Consent.

- 2) The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

- 3) I understand that, and consent to, the following that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning and leaving a message on my voice mail or with the individual answering the phone. I also understand my name may be viewed on a sign-in sheet, referral board, and/or clinic newsletter and may be called when the doctor is ready to see you.

- 4) The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific healthcare operations. This includes contacting my general physician, any specialists, and/or any other practitioners I have seen.

- 5) I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment, and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, the restriction is binding on the Practice.

- 6) I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

- 7) I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

- 8) I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read, and understand, the foregoing notice and all of my questions have been answered to my full satisfaction in a way that I can understand.

Signature of Patient

_____/_____/_____
Date

Life Enhancement Clinic, P.C. – Financial & Clinic Policies

Please read each section and **check the square** after reading each section. Please sign and date the bottom of this form.

- I understand that the policy of Life Enhancement Clinic, P.C. requires payment in full for all services rendered at the time of my office visit, unless other arrangements have been made. If co-payment is required this will be collected at each visit and I understand I will receive a statement for the non-covered portion of what was billed to my insurance provider.
- I understand that it is my responsibility to be aware of my insurance coverage benefits for chiropractic care. I understand it is my responsibility to be aware of my deductible and co-insurance policies
- I understand that health and accident insurance are an arrangement between my insurance carrier and me. I authorize Life Enhancement Clinic, P.C. to release any information to process insurance claims. However, I clearly understand and agree that I am ultimately responsible for payment of my account.
- I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will become immediately due and payable.
- I understand that regardless of my payment method, any nutritional supplements, supplies, equipment or educational materials I purchase must be paid for in full. These items will not be charged to my account and there is no refund for opened or used products. Unopened or unused products that have not expired, nor are within 60 days of expiration, may be returned for a credit (*excludes medical foods and probiotics*).
- I understand that some services provided at Life Enhancement Clinic, P.C. are not covered by my insurance provider. These include, but are not limited to, nutritional consultations, blood tests, saliva tests, hormone testing, stool tests, functional medicine evaluation, lifestyle coaching, wellness care or the like. I understand that I am responsible for any non-covered care. I understand that Life Enhancement Clinic, P.C. will not bill insurance on my behalf for functional medicine or clinical nutrition services.
- I understand that my appointments (office, phone or e-mail consultations) are established to seek professional medical advice. I understand appointments for services other than chiropractic care or rehabilitation are not submitted to my insurance provider based on the nature of the complaint. I understand that there is a \$55 charge per 15 minutes of the doctor's time. Lab fees are established and current pricing is available upon request.
- I understand that phone consults, e-mail questions, or other forms of contact that require a chart review, in depth response, or need for further evaluation will accrue a minimal fee. Simple questions that do not require a review of your personal records, etc will not be charged.
- I understand that my appointments and treatment plan scheduling reserves a block of time for me to adequately receive the necessary services. In the event I need to reschedule I understand a 24 hour notice is appreciated.
- I understand that it is important to keep my scheduled appointment and I should arrive a few minutes early to ensure I can be taken to a treatment room at my scheduled appointment time. I understand that the Life Enhancement Clinic, P.C. reserves the right to reschedule my appointment, or place me on a waiting list, if my tardiness would interrupt the rest of the scheduled patients.
- I understand that not all of my questions may be answered at every visit due to time constraints and I may need to schedule additional time to fully address these issues.

Patient Signature (or legal guardian)

Date