Dr. Jay Brodwyn
Dr. Michael Haniotis
Dr. LaShasta Robinson
Chiropractors

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Columbus, GA 31907
706-563-3370

INFORMED CONSENT TO CHIROPRACTIC CARE

Patient Name (printed)_____

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 there is anything that is unclear.

The nature of the chiropractic adjustment

Chiropractic is a physical, hands-on branch of the healing arts. The primary treatment that a Doctor of Chiropractic uses is called an "adjustment" or a "spinal manipulation". The purpose of the adjustment is to restore normal motion to the joints of your spine. In order to perform an adjustment, your Chiropractor may use his hands or a specialized mechanical instrument. You may experience a feeling of movement during an adjustment or hear an audible "pop" or "click" similar to "cracking" your knuckles.

It is important to understand that the Doctor may have to touch, palpate, and/or maintain contact with personal areas of your body in order to properly evaluate and treat your problem. Some examples are, but not limited to, the front of shoulder or chest, ribs (front and back), lower hips, buttocks, and groin. We make every attempt to make sure you are comfortable and encourage you to discuss any apprehensions you may have with the Doctor prior to each visit.

Examination/Treatment

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

palpation	radiographic studies	spinal manipulative therapy
orthopedic testing	vital signs	hot/cold therapy
basic neurological testing	postural analysis	EMS
range of motion	muscle strength testing	intersegmental traction
other:_____		

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, 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 complication including stroke. Some patients feel some stiffness and soreness following the first few days of treatment. We will make every reasonable effort during the examination to screen for contradictions to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform us.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

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 pain killers
- Hospitalization
- 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 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 reduce mobility which may set up a 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. I have discussed it with Dr. Brodwyn/Dr. Haniotis/Dr. Parish and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to treatment.

_____
Doctor's Name (printed)

_____ _____
Patient Signature Doctor's Signature

Date: _____ Date: _____

I, the undersigned, attest that I am the custodial parent or legal guardian of the above-referenced minor, and hereby authorize **BRODWYN & ASSOCIATES** to administer treatment as it so deems necessary.

_____
Signature of Parent or Guardian
(if a patient is a minor)

X-ray Consent and Authorization

In order for **Dr. Brodwyn and Associates** to fully evaluate your condition and to provide proper treatment, x-rays may be needed. By my signature below, I hereby authorize **Brodwyn and Associates** to perform such radiographic examination deemed necessary to diagnose and to treat my present problem.

Patient Name (printed)_____Date_____

Patient Signature _____

Signature of Parent or Guardian (if patient is a minor)_____

For Female Patients

The radiation used in x-rays may be harmful to an unborn child/developing fetus, especially during the first trimester. To help prevent the accidental irradiation of any unrecognized pregnancy, and in accordance with national standards, we require the following information from female patients of child bearing age:

Date of your last menstrual cycle:_____

Birth control measures:_____

Is there any chance you may be pregnant?_____

I have been fully informed of the risks involved in exposure to radiation during a first trimester pregnancy and assume the responsibility for any consequences from the procedures I am about to have. I agree that I will not hold **Dr Brodwyn and Associates** responsible for any potential harm to myself or my unborn child. By signing below, I consent to the necessary x-ray procedures.

Patient Signature:_____Date:_____

Signature of Parent or Guardian (if patient is a minor)_____

Brodwyn & Associates

NEW PATIENT/PATIENT UPDATE FORM

PLEASE FILL OUT COMPLETELY

Name _____ **Date** _____

Address _____

City_____**State**_____**Zip**_____**Phone #**_____

DOB _____ **SS#** _____ **Email** _____

Marital Status M S W D **Primary Medical Doctor**_____

Family Relative (not living with you) **Name** _____

Address_____ **Relationship** _____

City_____**State**_____**Zip**_____**Phone #**_____

PATIENT EMPLOYMENT INFORMATION

Employer _____

Address _____

Occupation _____ **Phone #** _____

INSURANCE

Insurance is in whose name Self ____ Parent ____ Spouse ____ Other _____

Policy Holders Name _____ **DOB** _____

Address _____

Phone# _____ **SS#** _____

INSURED EMPLOYMENT INFORMATION

(if different)

Employer _____

Address _____

Occupation _____ **Phone #** _____

DEMOGRAPHICS FOR YOUR ELECTRONIC HEALTH RECORD

Preferred Language _____

Smoking Status Never Former Occasional Smoker Daily Smoker

Race White Black/Afro-American Asian Native Hawaiian or other Pacific

Ethnicity Hispanic Non-Hispanic

Clinicare of Columbus, Inc.
DBA Brodwyn & Associates
3624 Edgewood Rd.
Columbus, GA 31907
Phone: 706-563-3370 ~ Fax: 706-563-3501

Patient Authorization

Standard Authorization of Use and Disclosure of Protected Health Information

Information to Be Used or Disclosed
The information covered by this authorization includes:

_____

_____

Persons Authorized to Use or Disclose Information
Information listed above will be used or disclosed by:

_____
Name of Person Organization

_____
Name of Person Organization

Expiration Date of Authorization
This authorization is effective through _____ unless revoked or terminated by the patient or patient's personal representative.

Patient Rights

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to this office and contact the Privacy Officer.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

I understand this office will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure.

If you understand and agree with all of the above policies, please sign your name below.

_____ _____
Patient or Legally Authorized Individual Signature Date

_____ _____
Print Patient's Full Name Time

_____ _____
Witness Signature Date