Dr. Jay Brodwyn Dr. Michael Haniotis
Dr. Ken Calain Dr. Janet Hyder
Chiropractors

3624 Edgewood Rd. Suite A
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. Calain and Dr. Hyder 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)_____

Clinicare of Columbus, Inc.
dba (Brodwyn & Associates)

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

I authorize Brodwyn and Associates to:

Speak with spouse about any insurance or health information:	Yes	No
Leave messages on home voice mail:	Yes	No
Leave messages on cell phone voice mail:	Yes	No
Speak with _____about any insurance or health information:	Yes	No

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

DR. JAY BRODWYN & ASSOCIATES

3624 EDGEWOOD RD
COLUMBUS GA, 31907
P-706-563-3370 F-706-563-3501
WWW.DRJAYBRODWYN.COM

Medical Record Release Form

Patient Name: _____ Date of Birth:_____

Address: _____

Phone # _____

I hereby request that my health care information be released from/released to the following office:

Clinic/Doctor Name: _____

Address: _____

Phone # _____ Fax# _____

Records requested: ☐ Office notes ☐ X-rays ☐ MRI reports ☐ All records

I understand that these records are protected under Federal and /or State law and cannot be disclosed without written consent unless otherwise provided by law. I understand that I have the right to revoke this consent at any time unless the facility, which is to make the disclosure of information has already done so in reliance on the consent.

Patient Signature_____ Date_____

Doctor's Signature_____ Date_____

Brodwyn and Associates
Jay Brodwyn, D.C.
3624 Edgewood Rd, Suite A
Columbus, Ga 31907
Phone: (706) 563-3370 Fax: (706) 563-3501
Email: drjaybrodwyn@gmail.com

ASSIGNMENT OF BENEFITS

Patient's Name: **Date of Incident:**

Insurance Company: **Claim#**

I do hereby authorize Brodwyn and Associates /Jay Brodwyn, D.C. to furnish my insurance company with a full report of my examinations, diagnosis, prognosis, etc. with regard to the accident of _____.

I hereby authorize and direct assignment of benefits under this arrangement such that any health insurance policy, medical payment coverage or third party insurer make payment for my chiropractic treatment directly to Brodwyn and Associates. I understand that this is an irrevocable assignment and lien.

I further understand that Brodwyn and Associates will prepare forms to assist me in making collection from my insurance carrier(s). I understand that any amount paid directly to Brodwyn and Associates by my insurance company will be credited to my account upon receipt.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for services rendered for me and that agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any recovery made by me. I hereby agree to waive the defense of Statue of Limitations as it pertains to any claim filed against me beyond three years (or other statutory) after services were rendered. I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest by signing this document, the doctor will not await payment but may declare the entire balance due and payable at the time of service.

_____ _____

Patient Signature **Date**

_____

Notary

Functional Rating Index

Please choose the answer that best describes each topic.

Pain Intensity
_____ No Pain
_____ Mild Pain
_____ Moderate Pain
_____ Severe Pain
_____ Worst Possible Pain

Sleeping
_____ Perfect sleep
_____ Mildly disturbed sleep
_____ Moderately disturbed sleep
_____ Greatly disturbed sleep
_____ Totally disturbed sleep

Personal Care (washing, dressing, etc)
_____ No pain; No restrictions
_____ Mild pain; No restrictions
_____ Moderate pain; Need to go slowly
_____ Moderate pain; Need some assistance
_____ Severe pain; Need 100% assistance

Travel (driving, etc)
_____ No pain on long trips
_____ Mild pain on long trips
_____ Moderate pain on long trips
_____ Moderate pain on short trips
_____ Severe pain on short trips

Work
_____ Can do usual work plus unlimited extra work
_____ Can do usual work; no extra work
_____ Can do 50% of usual work
_____ Can do 25% or usual work
_____ Cannot work

Recreation
_____ Can do all activities
_____ Can do most activities
_____ Can do some activities
_____ Can do a few activities
_____ Cannot do any activities

Frequency of Pain
_____ No pain
_____ Occasional pain; 25% of the day
_____ Intermittent pain; 50% of the day
_____ Frequent pain; 75% of the day
_____ Constant pain; 100% of the day

Lifting
_____ No pain with heavy weight
_____ Increased pain with heavy weight
_____ Increased pain with moderate weight
_____ Increased pain with light weight
_____ Increased pain with any weight

Walking
_____ No pain; any distance
_____ Increased pain after 1 mile
_____ Increased pain after 1/2 mile
_____ Increased pain after 1/4 mile
_____ Increased pain with all walking

Standing
_____ No pain after several hours
_____ Increased pain after several hours
_____ Increased pain after 1 hour
_____ Increased pain after 1/2 hour
_____ Increased pain with any standing

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