Hastings Sport and Spine

Functional Chiropractic Clinic

Joshua Geidel, DC

117 3rd St W Hastings, MN 55033

www.HastingsSportAndSpine.com

Acknowledgement of Receipt of Notice of Privacy Practices

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, [Patient’s Name] acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Hastings Sport and Spine Functional Chiropractic Clinic, which describes the Practice’s policies, and procedures regarding the use and disclosure of any of my Protected Health Information created, received, or maintained by the Practice.

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Date Signature D.O.B

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Primary Insurance Provider Insurance ID number

Consent for Purposes of Treatment, Payment, and Healthcare Outcomes

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [Name of patient or guardian] consent to Hastings Sport and Spine Functional Chiropractic Clinic’s (the Practice’s) use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice’s general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, clinical education, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice’s diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, “protected Health Information” means any information including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of healthcare services for me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have a right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment, or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have a right to review the Practice’s Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice’s duties regarding the types of uses and disclosures of Protected Health Information.   
 I have the right to revoke this consent, in writing, at any time, except to the extent that the Chiropractor or the Practice has acted in reliance on this consent.

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Signature of Patient or Guardian Printed Name of Patient or Guardian

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Date relation to patient

**Informed Consent in the State of Minnesota from the Patient**

You have the right as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you many make the decision whether or not to undergo such care after being advised of the known risks. This disclosure is not meant to frighten or alarm you. It is simply to make you better informed in order that you may give or withhold your consent.

**Introduction**

The Medical Practice Act of 1987 regulates the practice of medicine in the state of Minnesota. This Act governs physicians licensed to practice medicine in all of its branches as well as chiropractic physicians licensed to treat human ailments without the use of drugs and without operative surgery. Patient care provided by physicians including chiropractic physicians has known risks which may include death, brain damage, quadriplegia, paraplegia, the loss or loss of function of any organ or limb, or disfiguring scars associated with such care and treatment.

Chiropractic is a science which concerns itself with the relationship between structure (spine and joints) and function (primarily nervous system) of the body as that relationship may affect the restoration and preservation of health. For your information the following is routinely furnished to all who consider chiropractic care and treatment in this clinic.

**Nature and purpose of chiropractic**

Adjustments are made by chiropractors to correct spinal and extremity joint restrictions. Restrictions put joints in abnormal functional movements and can cause irritation to muscles and nerves and vessels. By adjusting the joints and releasing the muscle, it allows the doctor to restore proper motion and muscle firing patterns to the area. This often relieves pain and prevents the problem from worsening.

An adjustment is usually a quick precise movement over a very short distance to the spine or extremity. These adjustments will all be performed by hand. In addition, rehabilitative exercises may be performed to aid in the treatment. Muscle release involves pinning a muscle and taking it through normal range of motion. PIR stretching involves contracting and muscle and then pushing the barrier of end range until normal is met or no more range can be gained.

Not only should you understand the benefits of chiropractic care and treatment in restoring and maintaining good health, but also you should be aware of the existence of some inherent risks and limitations. These are seldom enough to contradict care, but should be considered in making the decision to receive chiropractic are. All health care procedures, including those used in varying degrees, have some risks associated with them. Risks associated with some chiropractic adjusting procedures may include musculoskeletal sprain/strain, neurological injury, fracture, vertebral artery syndrome (VAS) including stroke and perhaps, death through complicating factors. Risks associated with physiotherapy may include not only the foregoing but also allergic reaction, muscle, and or joint pain.

**AURTHORIZATION FOR CHIROPRACTIC CARE AND TREATMENT**

I have been informed of the nature and purpose of the chiropractic care, the possible consequences of the care, and the risks of the care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences, and probable effectiveness of each and I have been advised of the possible consequences if no care is provided. I acknowledge that no guarantees have been made ot me concerning the results of the care and treatment.

**I HAVE READ THE ABOVE PARAGRAHS. I UNDERSTAND THE INFORMATION PROVIDED. THE INFORMATION PROVIDED SHAS BEEN EXPLAINED TO ME AND ALL QUESTIONS WHICH I HAVE ARE ANSWERED TO MY SATISFACTION.**

**HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE HASTINGS SPORT AND SPINE FUNCTIONAL CHIROPRACTIC CLINIC TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT**

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**PATIENT OR GUARDIAN SIGNATURE DATE TREATING DOCTOR SIGNATURE**

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[www.HastingsSportAndSpine.com](http://www.HastingsSportAndSpine.com)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_ Gender: M F Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been under chiropractic care? Y N Currently? Y N who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about our office? Facebook Google Bing Other Internet Friend

Who referred you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health History**

Please indicate if you have ever had any of these in the past

Injury (last 12 months)……………..Y / N

Seizures…………………………………… Y / N

Loss of consciousness……………… Y / N

Fracture or dislocation……………. Y / N

Surgery (12 months)…………………Y / N

Hospitalization (12 months)……. Y / N

CAT SCAN or MRI…………………….. Y / N

Asthma…………………………………….Y / N

Dizziness…………………………………. Y / N

High Blood Pressure…………………Y / N

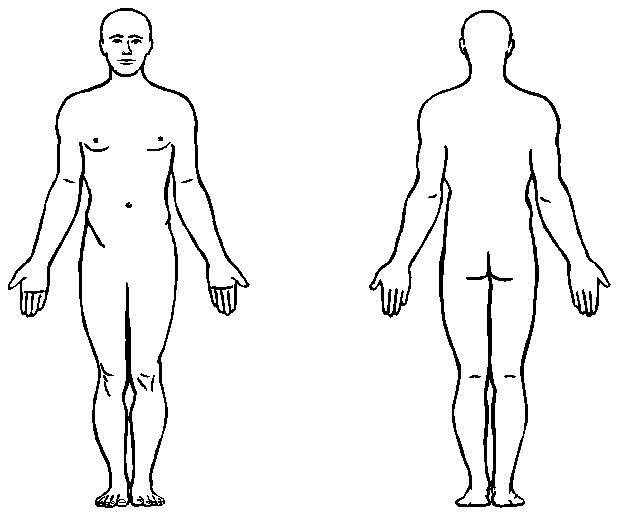
Diabetes………………………………….. Y / N

Prescription Medication………….. Y / N

Over the Counter Medication…. Y / N

Allergies……………………………………Y / N

Please mark the area(s) that are bothering you If yes to any of the above questions, please elaborate here:

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