Consent for Treatment and Acknowledgement of Receipt of Information

To the patient: Every type of health care is associated with some risk of potential problem. Health care providers, including chiropractors, are required by law to tell you the nature of your condition, the general nature of the treatment, the risks involved, and the reasonable therapeutic alternatives. In keeping with the Oregon law of informed consent, you are being asked to sign a confirmation that we have discussed all these matters. We have already discussed with you all the problems and the risks. Please read this form carefully. Ask about anything you do not understand, and we will be pleased to explain it. In general, chiropractic treatment includes examination, taking of x-rays, manipulation/adjustment, and application of physiotherapy modalities. Although their occurrence is extremely remote, some risks are known to be associated with these procedures. These include:

1) Stroke: Stroke is the most serious problem associated with spinal manipulation. The results can be temporary or permanent dysfunction of the brain, with a very rare occurrence of death (1 in 20 million). Spinal manipulations have been associated with strokes that arise from the vertebral artery (located in the neck vertebrae). This problem occurs so rarely that there is no conclusive data to quantify probability.
2) Disc herniations: Disc herniations that create pressure on the spinal nerve or spinal cord are frequently successfully treated by chiropractors. Rarely, treatment may aggravate the problem resulting in increased low back pain, radicular pain, and numbness of a transient nature. Residual pain may last for several days but seldom for longer periods of time.
3) Soft tissue injury: Soft tissue primarily refers to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely, treatment may aggravate some muscle or ligament fibers. The result may be a temporary increase in discomfort, but there are typically no long-term effects for the patient.
4) Rib fractures: The ribs are found only in the thoracic spine or middle back. Rarely, a manipulation will fracture a rib bone. This occurs only on patients who have weakened bones from such things as osteoporosis. We adjust all of our patients very carefully, especially those who may be at risk of having a weakened bone condition.

I hereby authorize and direct Dr. Charles Goldston, D.C. and Dr. William Jackson, D.C. together with associates and assistants of their choice to provide chiropractic treatment including spinal manipulation/adjustment, diagnostic testing, various types of physiotherapy, and any other additional procedures that are deemed reasonable for the treatment of my condition. This treatment has been explained to me and alternative methods of treatment, if any, have also been addressed. I have read and understand all the information set forth in this document including any attachments. I acknowledge that I have had the opportunity to ask any questions about the contemplated procedures and that they have been answered to my satisfaction. This authorization for and consent to chiropractic treatment is and shall remain valid until revoked.

Patient's name_____**Date**_____**Time**_____
Signature of patient, parent or guardian_____
Relationship to patient_____
I certify that I have provided and explained the information set forth herein, including any attachments, and I have answered all questions concerning proposed treatment to the best of my knowledge and ability.
Signature of Chiropractor_____**Date**_____**Time**_____

FINANCIAL POLICY

1. **Responsibility for Payment:** We consider the patient to be responsible for payment of services. In cases where the patient is a minor, the parent that the child is living with is responsible for payment.
2. **Insurance Billing:** As a courtesy to you, we will bill your primary insurance company provided that the pertinent identification numbers are provided. It is the patient's responsibility to inform our office of ANY insurance changes.
3. **Auto Insurance:** If patient is involved in an automobile accident, the responsible party is the insured automobile the patient was in at the time of the accident. The patient is required by this office to fill out and sign all lien agreements.
4. **Major Medical Insurance:** If your annual insurance deductible has not yet been met, payment is expected at the time of service. Insurance is considered to be a private contract between the patient and insurance company: it is the patient's responsibility to resolve any difficulties with claims processing directly with the insurance company. We will call for benefits, but there is **NO GUARANTEE OF BENEFITS**.
5. **Workers Compensation:** If an injured worker has completed the appropriate forms in our office, we will bill his/her industrial accident insurance.
6. **All Insurance Claims:** Any amount not covered by major medical insurance, auto insurance, workers compensation insurance is the **FULL RESPONSIBILITY** of the patient or patient's guardian.

I, _____, have read this financial policy and understand its content.
(Please Print)
Signature of Patient/Guardian_____ **Date**_____

STARKWOOD CHIROPRACTIC

Doctor's Lien and Assignment of Right to Recovery

I do hereby authorize Starkwood Chiropractic Clinic to furnish you, my attorney and/or insurance carrier, with information regarding the accident in which I was involved.

I understand that I am directly responsible to Starkwood Chiropractic Clinic for any and all bills submitted for services. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. In consideration of not having to immediately pay debt, I hereby assign and convey to Starkwood Chiropractic Clinic a legal and equitable interest in any and all causes of action of rights of recovery. I also understand that a nine percent interest charge will be accrued to any balance held over ninety days until my balance is zero.

I hereby authorize my attorney, and insurance company to pay directly to Starkwood Chiropractic Clinic, that which is owing for professional services as a result of this accident and by reason of any other bills that are due to Starkwood including attorney fees. These are to be withheld from any settlement or judgment I hereby further give a lien on my case to Starkwood Chiropractic Clinic against any and all proceeds of my settlement, judgment or verdict which may be paid to you as result of the injuries for which I have been treated.

I further instruct a separate check to be issued to Starkwood Chiropractic Clinic for services rendered.

I have read this document, I understand it, and I voluntarily agree to be bound by it. I am directing my attorney to protect Starkwood Chiropractic Clinic interest as provided herein.

_____ _____ _____

Patient Name (PRINT) Patient Signature Date

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary adequately to protect the said doctor named above.

_____ _____ _____

Attorney Name (PRINT) Attorney Signature Date