Terms of Acceptance

AS USED IN THESE DOCUMENTS, THE TERMS "WE", "OUR" AND/OR "US" REFERS TO THE LEGAL OWNER AND OPERATOR OF GROVETOWN ACCIDENT REHAB.

Explanation of Services

Daily activities cause subluxations of the spine. Also know as joint fixations, subluxations create interference in the neuro-electrical communication in the spine and extremities. This causes poor joint motion, pain, discomfort and disfunction. Chiropractic focuses on the conditions that result from these subluxations and their effects on general health.

Our purpose is to provide routes toward health and wellness through ongoing chiropractic care consisting of maintenance and preventative care. The health and safety of our community is our primary concern. Hence, we only accept patients that, after assessment, are going to benefit from our care. Here is what our services will and will not do:

WHAT WE DO

We offer an affordable and convenient entry into healthcare through routine chiropractic care leading to improved function, healthier and more active lifestyle.

We remove subluxations through the application of a targeted pressures to joints of the body determined by a licensed chiropractor. These specific pressures relieve joint immobility and help improve function of the spine and extremities.

WHAT WE DON'T DO/SERVISE LIMITS

We do not treat any condition of the of the body except subluxations.

We do not accept or bill insurance for our memberships.

We do not have diagnostic equipment such as x-rays

Our services are limited to providing the reparative and preventative effects of routine chiropractic care to improve function in the spine and extremities.

If the doctor's professional opinion is that a patient needs additional testing or another form of healthcare, the patient will be referred to an appropriate facility or provider.

FINANCIAL RESPONSIBILITY

Payment options available if the Doctor of Chiropractic determines that our care is appropriate and has gone over a plan of care.

Patients attest that they are responsible to remit full payment for services provided. Patients also acknowledge we do not bill or submit any claims for, or on, their behalf to any private insurance, Medicare, Secondary Medicare, etc., unless required by law.

CONSENT

I, _____ have read and fully understand the above statements. All questions regarding the doctor's objective about my care have been answered to my satisfaction. Therefore, I accept all chiropractic care provided to me based upon these guidelines.

Signature _____ Date _____

CONSENT TO EVALUATE AND TREAT A MINOR CHILD

I, _____ of _____ have read and fully

understand the terms of acceptance and grant permission for _____ to receive chiropractic care.

Signature _____ Date _____

Patient information

First Name _____ Last Name _____

Gender: Male / Female Date of Birth _____/_____/_____ Age _____

Home address _____

City _____ State _____ Zip Code _____

Cell Phone _____ Home Phone _____

Email _____

Preferred method: call text email

Employer

Work Address _____

City _____ State_____ Zip Code _____

Emergency Contact _____ Phone _____

Are you eligible for Medicare? Yes No

Do you have a Health Savings Account (HSA) or Flexible Spending Account (FSA)?

How did you hear about us? _____

How far did you travel to get here today? _____

Please tell us if someone referred you so we may thank them. _____

Patient History

Name _____ Age _____ DOB _____/_____/_____ Gender M F

Height _____ Weight _____Occupation _____ How Long?_____

Chiropractic care before? Y N How recent? _____

2. Reason for visit today?

Pain Discomfort Stiffness Maintenance Injury `Other _____

When did it start? _____ Is it getting: Better Worse

What helps: _____ What worsens? _____

Where is your area of complaint?

Describe what it feels like? _____

Have you had this before? _____ When? _____

Headache/Migraine	Neck	Shoulders	Arm	Elbow
Wrist	Upper Back	Middle Back	Lower Back	Hip
Sciatica	Knees	Ankles		

Are you pregnant? _____ How many weeks? _____

Are you experiencing any of the following?

Nausea/vomiting Rapid Eye Movement Numbness on one side of the face/body Fainting Dizziness

Difficulty walking Difficulty Speaking Difficulty Swallowing Double Vision Severe Headache/Neck Pain

Describe? _____

Current Medications: _____

History

Arthritis	Fuses joints	Herniated disc	Joint replacement	Osteoporosis	Osteopenia
Cancer	Tumors	Stroke	Seizures	Pacemaker	High blood pressure
Heart disease		Aids/HIV	Diabetes	Hepatitis	Tuberculosis

Surgeries? Y N When? _____

Accident/broken bones? Y N When? _____

Hospitalizations Y N When? _____

Please describe

Family History:

Cancer Tumors Stroke Seizures Diabetes HBP Heart Disease

Signature _____ Date _____

INFORMED CONSENT

We provide adjustments or manual manipulation through gentle pressure applied to the joints of the spine and extremities when and where indicated by a licensed Doctor of Chiropractic to improve motion in those joints.

Chiropractic treatment, including spinal adjustments, have been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated as an effective treatment for neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other symptoms. Routine Chiropractic care can result in better function, improve joint motion and a healthier and more active lifestyle.

However, there are some risks associated with chiropractic treatment including but not limited to sprains/strains, dislocation or fractures. In addition:

1. While rare, some patients may experience short term aggravation of symptoms, rib fracture, muscle/ligament sprain/strain as a result of manual manipulation.
2. There are report cases of stroke associated with neck movements including adjustments of the upper cervical spine. Current medical and scientific evidence does not provide a definitive cause and effect between upper cervical spinal adjustments and stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of the association because stroke can have serious neurological impairment including paralysis.
3. There a reported cases of disc injuries following spinal adjustments o chiropractic treatment

The risk of injury from chiropractic treatments are substantially lower than that associated with many medical treatments, medications, surgical procedures given for the same treatments

Common alternatives adjustments include medications, physical therapy, other medical treatments and surgeries provided by physicians and surgeons.

By signing this informed Consent, I acknowledge that I have discussed, or had the opportunity to discuss, with my Doctor of Chiropractic; including the nature and purpose of chiropractic treatment in general and my treatment in particular , including spinal adjustments, the benefits, risks and alternatives to chiropractic treatment.

I consent to the chiropractic treatments offered or recommended to me by mt Doctor of Chiropractic, including spinal adjustments. I intend this consent to apply to all my present and future chiropractic care from Grovetown Accident Rehab.

Dated this _____ day of _____ 20 _____

I understand and informed that some risks are associated with chiropractic adjustments. These include but are not limited to sprains, dislocations, fractures, disc injuries strokes and paralysis.

Patient _____ Date _____

Doctor _____ Date _____

PRIVACY PRACTICES

THIS NOTICE DESCIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY US, ODOM CHIROPRACTIC, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

If you have any questions about this notice, please contact our office.

Who will follow this Notice?

1. Odom Chiropractic.
2. Doctor of Chiropractic that provide services to you at Odom Chiropractic.
3. Employees and contractors of Odom Chiropractic.

We understand that medical information about you is personal and we are committed to protecting this information. When we deliver chiropractic treatment, a record of the encounter is made. Typically, this record includes your treatment plan, your history and physical, any x-rays and/or test you provides us, and billing record. This record serves as a:

1. Basis for planning your care.
2. Communication tool between chiropractors and staff and your other health care providers that you wish us to share.
3. Tool for assessing and continually working to render improved care and outcomes.

This Notice tells you the ways we may use and/or disclose you Protected Health Information ("medical information"). It also describes your rights and obligation regarding the use and disclosure of medical information.

OUR RESPONSIBILITIES

We are required by law to:

1. Maintain privacy and security of your medical information.
2. Proved you with notice of our legal duties and privacy practices with respect to the information we collect and maintain about you.
3. Abide by the terms of this Notice.
4. Notify you if we are unable to agree to a requested restriction.

THE METHODS WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following shows how we use and disclose your medical information. The following is for guidance as does not include every possible use or disclosure:

1. For Treatment: We will use and disclose your medical information to provide, conduct, coordinate and manage your care at our facility.
2. For Payment: we will use and disclose your medical information to collect payment for services rendered from you or another party.
3. For Health Care Operations: We may use and disclose your medical information for our office operations. These uses and disclosures are necessary for the office to run smoothly and efficiently to provide quality care to all that seeks it. Your medical information may be used in the evaluation of services, appropriateness of care we provide. Some of your medical information may be overheard by others during care. Should you need to speak privately with the doctor or a member of our staff, we have a separate space available for privacy. If the law permits, we may use cameras or other recording devices and a notice will be posted of the use of such equipment.
4. For Contacting You: We may use your medical information to contact you regarding you care, provide notifications, birthday and holiday relates messages. Text messages, billing questions. If contacted by phone we may leave a message by voicemail or answering machine.
5. Appointment Reminders: We may use and disclose your medical information to contact you about appointments.
6. As Required by Law: We will disclose medical information about you when required by federal, state laws and regulations.
7. Health Oversite Activities: We may disclose medical information to health oversight agencies for activities authorized by law. These agencies include public and private agencies authorized by law to oversee the health care system. The activities include audits, investigations, inspections, and licensure. These are necessary for the government to monitor the health care system, government programs, eligibility or compliance and enforce related health related civil rights and criminal laws.
8. Lawsuits and Disputes: If you are involved in certain lawsuits or administrative disputes, we may disclose your medical information in response to a court or administrative order.
9. Law Enforcement: We may disclose your medical information in response to a law enforcement officials court order or subpoena
10. Electronic Disclosure: If needed, we may disclose your medical information to another healthcare provider electronically.

DISCLOSURES REQUIRING AUTHORIZATION

Marketing: Marketing generally includes s communication made to describe a health-related product or service that may encourage you to purchase or use the product or service. We obtain your written authorization to use or disclose medical information for marketing unless the communication is face to face, involves a promotional gift of nominal value or otherwise prohibited by law. All other marketing uses, and disclosures require your written permission which you may revoke at any time.

YOUR RIGHTS REGUARDING YOUR MEDCIAL INFORMATION

You have the following rights regarding collection and maintaining of your medical information:

1. Right to inspect and copy. The right to inspect and copy medical information that we may use to make decisions about your care. Usually, this includes medical and billing records. To inspect and copy your medical information submit your request in writing to us. You can also request to inspect and copy electronically.
2. Right to Amend. If you feel medical information maintained is incorrect or incomplete, you may ask us to amend to information. You may ask for an amendment for as long as we keep the information. You must provide a reason for the request. We may deny your request if not in writing or does not provide supporting reason for the request. Additionally, we may deny your request if you ask us to amend information that:
    1. Was not created by us, unless the entity that created the information is no longer available to make the amendment.
    2. Is not part of the information we keep at Odom Chiropractic.
    3. Is not part of the information you which you would be permitted to inspect and copy.
    4. Is accurate and complete.
    5. That violated law.

Right to Accounting of Disclosures: To request an "accounting of disclosures." This is a list of disclosures made of your medial information for purposes other that treatment, payment, or health care operations. To request this list you must submit you request in writing to us. Your request must state a time period, which may not be longer than six years. Your request must include in what form you wont the list. The first list requested will be free.

Right to Request Restrictions: To request a restriction or limitation to your medical information we use and disclose about your treatment and payment. You also have a right to request a limit on the medical information we disclose about you to someone who is involved with your care or the payment for your care. We are not required to agree to your request, but should we agree, we will comply with your request unless the information is needed to provide emergency treatment. To request restriction, you must make your request in writing and include what information you want and whether you want to limit our use and disclosure and to whom you want the limits to apply.

Right to Revoke an Authorization: There are certain types of uses and disclosures that require your expressed authorization. For example, we may not sell your information to a third party for marketing purposes without first obtaining your authorization. If you provide authorization to a particular use or disclosure of your medical information, you may revoke your authorization in writing by contacting us. We will honor your revocation except to the extent that we have already acted in reliance of the specific authorization.

Right to Receive a Copy Of this Document: You have a right to a copy of this document upon request.

CHANGES TO THIS NOTICE

We reserve the right to change our privacy practices and to make new provisions effective for all medical information we maintain. Should our privacy practices change, we will post the amended Notice of Privacy Practices in our office and website. You must request that a copy be provided to you by contacting us.

I understand and agree to the privacy practices notice that was presented to me. I also acknowledge that a copy will be made available upon request.

Printed Name _____

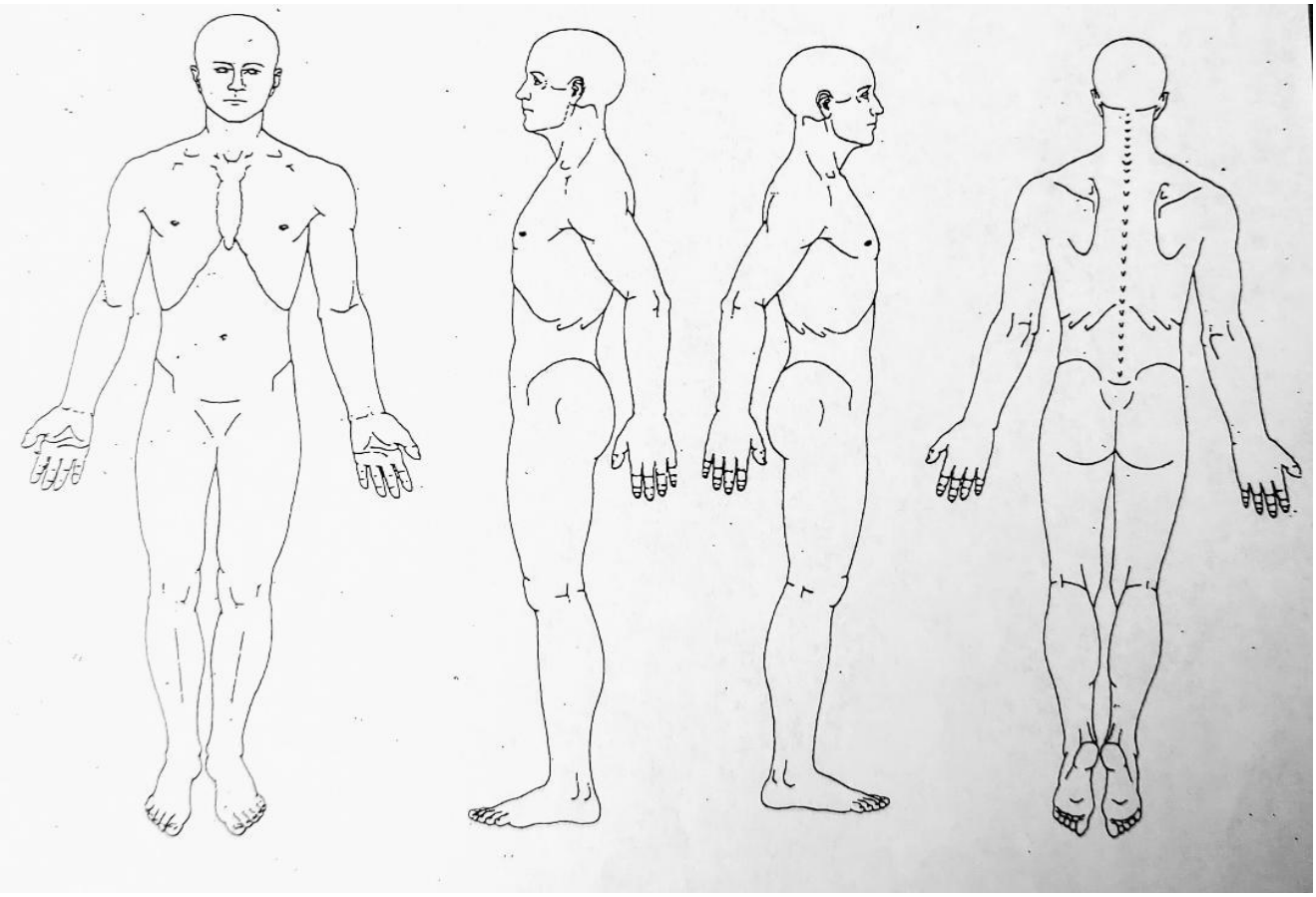
Signature _____ Date _____

Witness _____ Date _____

Patient History

Pain Location

Please mark the areas of your complaint on the diagram.



Please indicate what best describes you condition:

Pain	Numbness	Tingling	Burning	Cramping
Dull	Achy	Sharp	Shooting	Radiating