BRINEGAR CHIROPRACTIC CENTER; DR. KENNETH BRINEGAR DC

PATIENT CONSENT

For use and/or disclosure of protected health information to carry out treatment, payment, and healthcare options.

_____, hereby states that by signing this consent, I acknowledge and agree as follows:
(Print Name)

1. You have the right to a paper copy of the Notice of Privacy Practices for your review before signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures or my protected health information ("PHI") necessary for the practice to provide treatment to me, and also necessary for BCC (Brinegar Chiropractic Center) to obtain payment for that treatment and to carry out its health care operations. BCC has explained to me that the Privacy Notice will be available to me in the future at my request. BCC has further explained my right to obtain a copy of the Privacy Notice prior to signing the Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. BCC reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders that will be used by BCC:
    a. a postcard mailed to me at the address I have provided
    b. telephoning me at home or on my cell phone, and leaving a message on my answering machine or with an individual answering the phone
    c. email reminders, offers, updates, and promotions
    d. appointment reminders via text message at the number I have provided

4. BCC may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided at home) in order for BCC to treat me and obtain payment for that treatment, and as necessary for BCC to conduct its specific health care options.

5. I understand that I have a right to request that BCC restrict how many PHI is used and/or disclosed to carry out treatment, payment, and/or healthcare operations. However, BCC is not required to agree to any restrictions that I have requested. If BCC agrees agrees to a requested restriction, the restriction is binding on BCC.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for *future* transactions, with the understanding that any such revocation shall not apply to the extent that BCC has already taken action in reliance on this Consent.

7. I understand that if I revoke this consent at any time, BCC has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, BCC is unable to treat me.

9. It is the practice of this office to provide chiropractic care in an "open adjusting" and "open door" environment. This environment is used for ongoing care and is NOT used for taking patient histories, performing examinations, or presenting reports and/or findings.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____
Name of Individual (Printed) **Signature of Individual**

_____ _____
Signature of Legal Representative **Relationship to Patient**

(e.g, Attorney-In-Fact, Guardian, Parent if a minor)

Date signed ____/_____/_____ **Witness: _____**

FINANCIAL POLICY

BRINEGAR CHIROPRACTIC & MASSAGE CENTER

DR. KENNETH BRINEGAR D.C.

Insurance billing is done as a courtesy to the patient. Payment is expected at the time of services rendered, unless other arrangements are made in advance. While we attempt to verify coverage, BRINEGAR CHIROPRACTIC & MASSAGE CENTER; Dr Kenneth Brinegar D.C. is not responsible for quoted services your plan covers, and to what extent.

CASH PATIENTS: If you have no current insurance coverage, or your plan does not cover our services, you are considered a cash patient. Payment is expected in full each visit.

INSURANCE: We will assist you with your insurance plan and bill your insurer, but ultimately your insurance is a contract between you and your insurance company. Understanding the nature and extent of your coverage is your responsibility. Payment for co-payments, deductibles, and non-covered services are payable at the time of your visit.

AUTO ACCIDENTS: Patients are responsible for their bills regardless of who is at fault. We will bill your auto-med carrier, if you have one, or expect your attorney to honor our lein. You are responsible for your account. If you receive payment from 3rd party insurance, you are required to forward payment to BRINEGAR CHIROPRACTIC CENTER; Dr. Kenneth Brinegar D.C.

WORKER'S COMPENSATION: By law, the cost of treatment for work injuries is covered by your employer.

BOUNCED CHECKS: There is a $35 fee for any returned checks.

MISSED APPOINTMENTS: Maintaining your treatment schedule is very important. Please give 24 hours notice of cancellation to avoid a broken or missed appointment charge of $25 or more. If you miss too many scheduled appointments, you may be released from care. Emergencies are taken into consideration.

I agree to be responsible for and pay all costs of collection, including but not limited to attorney's fees incurred in the event that I do not pay my bill. I understand that there is a 3% interest charge per month on unpaid balances over 30 days past due.

By executing this document and accepting treatment, I agree that any payments that are made by an insurance company will be made directly to the doctor. I will execute any documents necessary to accomplish this, or I will pay In full as services are rendered and await insurance payment myself. In the event that insurance payment should come to me for whatever reason, I agree to immediately deliver payment to BRINEGAR CHIROPRACTIC & MASSAGE CENTER; Dr. Kenneth Brinegar D.C.

I authorize BRINEGAR CHIROPRACTIC & MASSAGE CENTER; Dr. Kenneth Brinegar D.C. to release all relevant information regarding my case to my insurance company, attorney, other health care provider, and to allow BRINEGAR CHIROPRACTIC & MASSAGE CENTER; Dr. Kenneth Brinegar D.C. to file a complaint with the insurance commissioner against my insurer, if necessary to collect my benefits. By my signature below I indicate that I have read and understand the extent and intent of this agreement.

Agreed this _____ day of _____, _____ in California.
Day Month Year

Patient/Guardian signature _____

Print Name _____

INFORMED CONSENT

BRINEGAR CHIROPRACTIC & MASSAGE CENTER;
Dr. Kenneth Brinegar, DC

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 chiropractic adjustment/manipulation:
The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible “pop” or “click”, much as you have experienced when you “crack” your knuckles. You may feel a sense of movement.

Examination / Treatment
As a part of the examination and treatment we provide, you are consenting to the following procedures:

- Spinal Manipulative Therapy
- Range of Motion Testing
- Muscle Strength Testing
- Ultrasound
- Radiographic Studies
- Palpation
- Orthopedic Testing
- Postural Analysis
- Hot/Cold Therapy
- Low Level Laser
- Vital Signs
- Basic Neurological Testing
- EMS
- Other (please specify) _____

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 complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care, however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring:
Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and x-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and estimated to occur between one in one million and one in five million in 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, injections, and painkillers
- Hospitalization
- Surgery

If you chose to use one of the avone and 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 adjustments and related treatment. I have discussed it with *Dr. Kenneth Brinegar DC* ☐ and have had any questions answered to my satisfaction. ☐ By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby consent to that treatment.

_____	_____
Name of Individual (Printed)	**Signature of Individual**
_____	_____
Signature of Legal Representative or Guardian (e.g, Attorney-In-Fact, Guardian, Parent if a minor)	**Relationship to Patient**

Date signed ____/_____/_____ **Witness: _____**