Stamford Family Wellness
1360 Bedford Street
Stamford, CT 06905
(203) 348-8383

Informed Consent Document

Patient Name: _____

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.

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 experience when you "crack" your knuckles. You may also feel a sense of movement.

Analysis/ Examination/ Treatment

As part of the analysis, examination, and treatment, you are consenting to the following procedures: (Please initial each procedure you consent to)

___ spinal manipulative therapy
___ range of motion testing
___ muscle strength testing
___ ultrasound/ cold laser
___ radiographic studies
___ palpation
___ orthopedic testing
___ posture analysis
___ hot /cold therapy
___ other (please explain)
___ vital signs
___ basic neurological testing
___ electric Muscle Stim.

_____

_____

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complication, 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 soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care, however, of you have a condition that would otherwise not come to my attentions, and 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 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. Ortelli and 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 that is in my best interest to under go the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

_____
Patient's Name

_____
Signature

_____
Signature of Parent or Guardian
(if a minor)

Dated: _____

_____
Doctor's Name

_____
Signature

Stamford Family Wellness
1360 Bedford Street
Stamford, CT 06905
Office: (203) 348-8383 Fax: (203) 961-1561

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Stamford Family Wellness we may use or disclose personal and health related information about you in the following way:

*Your personal health information, including of your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment. *Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services. *Your name, address, phone number, and your health care records may be used to contact your regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left of your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide authorization it will not affect the care provide to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances

*If we are providing health care services to you based on the orders of another health care provider.
*If we provide health care services to you in an emergency
*If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
*If there are substantial barriers to communicating with you, but in our professional judgement we believe that you intend for us to provide care.
*If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like

to receive this information at an address other than your home or, if you would like the information in a different form please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on the privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding out privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to Dr. Damian Ortelli immediately.

If you would like to further information about our privacy and practices please contact Dr. Damian Ortelli.

This notice is effective as of April 1, 2003. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Name (Printed please) _____ Signature _____ Date _____

If you are a minor, or if you are being represented by another party

Personal Representative (Print) _____ Personal Representative (Signature) _____ Date _____

Description of the authority to act on behalf of the patient.

Stamford Family Wellness
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Stamford, CT 06905
(203) 348-8383

Assigned Benefits Form

Name of Patient _____

Patient ID # _____

Claim # _____

Date _____

I request that payment of authorized benefits be made to Stamford Family Wellness, for any services rendered. I authorize that payment for services rendered be sent directly to Stamford Family Wellness at the above listed address.

I authorize any holder of medical information about me to be released if needed to determine these benefits for related services.

I understand that I am financially responsible to Stamford Family Wellness if services recommended are not covered under my heath plan, if my eligibility is not confirmed prior to treatment, if charges for services exceed my plan's maximum benefits or if my employment or insurance status has been altered.

Patient Signature _____

Date _____