Langel Chiropractic Clinic, P.C.

® 5907 Ashworth Rd, West Des Moines, IA 50266 ® Ph. 515-267-1600 ® Fax 515-267-1600

HIPAA/FINANCIAL POLICY/CONSENT TO TREAT A MINOR

Patient's Name:_____Date:_____Patient ID#_____
First MI Last

PATIENT PRIVACY (HIPAA):
I understand that I have certain rights to privacy regarding my protected health information and have been offered a copy of these rights. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to provide treatment.

Patient, Parent or Guardian's initials_____

FINANCIAL POLICY/CHIROPRACTIC INSURANCE:
I agree to assume financial responsibility for treatment costs and understand payment is due at the time of treatment, unless other arrangements have been made. If I have chiropractic insurance, my portion of the treatment costs are required at the time of treatment. I understand that if my chiropractic insurance company rejects paying for treatment, I will assume full responsibility for the account balance. I understand that any estimate of my treatment cost given for my portion is simply an estimate and may fluctuate depending on my insurance company's usual and customary fees. In case of default of payment, patient or responsible party agrees to pay all costs of collection including attorney fees, collection fees, and contingent fees. In the case of court action, the patient or responsible party is responsible for any court cost, serving fees, or attorney fees.

Patient, Parent or Guardian's initials_____

Patient, Parent or Guardian's signature:_____Date:_____

CONSENT TO TREAT A MINOR:
I hearby authorize Dr. Rodney D. Langel, D.C. and whomever he may designate as assistants to administer examinations and chiropractic care as deemed necessary to:

Minor Patient's Name:_____

Signature of Parent or Guardian:_____

Witness:_____Date:_____

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LETTER OF INFORMED CONSENT FOR LANGEL CHIROPRACTIC CLINIC P.C.

Patient Name: _____ Patient No:_____

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

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

Patient should initial the below procedures they are consenting to:

___Spinal adjustment
___Physical examination
___X-rays
___Intersegmental Traction
___Electronic Muscle Stimulation
___Laser Light Therapy
___Ultrasound
___Hot/Cold Therapy
___Pulsed Magnetic Therapy

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 contribution 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 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 treatments" 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 APPROPRAITE BLOCK [ ] AND SIGN BELOW.
I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. If needed, I have discussed it with Dr. Rodney Langel, D.C. 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 it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____ **Dated: _____**

_____ _____

Patient's Signature **Doctor's Name**

_____

Signature of Parent or Guardian (if a minor)