

PATIENT CONSENT AUTHORIZATION

CONSENT FOR TREATMENT:

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physicians.

RELEASE OF INFORMATION:

By signing this form, you are granting consent to **ABSOLUTE BODY, P.A.** to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office at 281-496-3355. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

MEDICARE AND MEDICAID CONSENT TO RELEASE INFORMATION:

I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim.

INFORMED CONSENT TO PARTICIPATE IN ACTIVE REHABILITATION THE GOALS OF THE REHABILITATION PROGRAM INCLUDE:

1. Determining the cause and extent of your problem.
2. Providing a therapeutic exercise program to strengthen you, increase your cardiovascular endurance, range of motion and flexibility, and decrease your pain.
3. Return you to full-duty, non-restricted work status and lifestyle.

THE EQUIPMENT USED TO TEST YOU AND THE PROCESS WE WILL BE USING WILL BE EXPLAINED TO YOU.

Your participation in the rehabilitation program is voluntary. You can stop at any point in the program. Should you stop your program, we are obligated to notify your doctor, insurance company, attorney, and DVR manager, if it is applicable. If at any point during the evaluation or rehabilitation process you have any questions, we will answer them to the best of our ability or refer you to someone more qualified. Please be advised that there are no guarantees that your personal goals and/or those listed above will be met to your satisfaction. The success of any rehabilitation process lies in the combined efforts of you and your provider. The “team” approach has the best chance of attaining your goals, so please ask as many questions as necessary for you to gain the maximum benefit from your rehabilitation program. Since the process of strengthening and conditioning are a form of “controlled strain”, there is a chance of aggravation or injury. It is therefore imperative that you communicate to your provider any aggravation or injury that you may observe during the rehabilitation process. For example, the *best* exercise for you, if performed too early in your condition, may be your *worst* enemy if performed too soon. Communication with your provider will help put into perspective problems that may occur. Failure to discuss problems may only foster additional problems down the road.

Research concerning the rehabilitation program and results may be conducted. Data will be used from the participant’s evaluations and exercise program. No names will be used and all information is strictly confidential.

Chiropractic, as well as all other health professions, is associated with potential risks in the delivery of treatment. Therefore it is necessary to inform the patient of such risks prior to initiating care. While Chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment. Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Chiropractic adjustments and physical therapy procedure are sometimes accompanied by post treatment soreness, disc injury aggravation, minor joint, ligament, tendon, or other soft tissue injury, minor burns to the skin while receiving moist heat as well as rare rib injury or fracture from thoracic spine adjustments. Stroke is the most severe complication of Chiropractic treatment, as well as the least occurring; with the estimated incidence of this type of side effect are 1 in 3 million upper cervical adjustments (JMPT 1996; 19; 37). Precautions such as pre-treatment history, examination, and x-rays prior to care minimize such risks, as well as performing all treatment carefully. These are not a normal and acceptable accompanying response to chiropractic care and physical therapy. Please advise your doctor if you experience any soreness, discomfort, dizziness, headache, tiredness, nausea, vomiting, loss of balance, or any other side effects or symptoms.

I understand that the physician, medical personnel and other assistants will rely on statements about the patient, the patient's medical history, and other information in determining whether to perform the procedure or the course of treatment for the patient's condition and in recommending the procedure which has been explained. I understand that the practice of medicine is not an exact science and **NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME** concerning the results of any procedure. I consent to diagnostic studies, x-ray examinations, and any other treatment or courses of treatment relating to the diagnosis or procedures described herein. By signing this form, I acknowledge that I have read or had this form read and/or explained to me, that I fully understand its contents that I have been given ample opportunity to ask questions and that any questions have been answered satisfactorily. All blanks or statements requiring completion were filled in and all statements I do not approve of were stricken before I signed this form. I also have received additional information including but not limited to the materials listed below, related to the procedure described herein. I hereby voluntarily request and consent to the performance of the procedures described or referred to herein by Doctors at this facility and any other physicians or other medical personnel who may be involved in the course of my treatment.

VERIFICATION OF NON-PREGNANCY (Female Patients Only):

By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____

X _____

Print Patient's Name

X _____

Patient's Signature

X _____

Other Than Patient, Print Name & Relationship

X _____

Witness