Chiropractic Spine & Sports Medicine

Dr. Scott F. Gillman

PATIENT INFORMED CONSENT TO TREATMENT

The nature of chiropractic treatment: The doctor will use hands or mechanical devices in order to move your joints and mobilize soft tissues (e.g. muscles, ligaments). A "crack" or "pop" sound is an inherent, natural effect of joint movement. Various other procedures, including, but not limited to hot packs, therapeutic ultrasound, laser, extracorporeal shock wave therapy, exercises and massage or other soft tissue therapies may also be used. ***Physical examination requires physical contact***: it involves the doctor manually challenging your joints and testing your muscle strengths which can sometimes lead to temporary soreness or worsening of your pain. Treatment is very hands-on and involves a lot of clinical body contact by your doctor, especially for procedures such as deep tissue massage and stretching. ***Please inform your doctor if you have any concerns about your safety or comfort before, during or after your treatment.***

Possible risks and side effects: As soon as *any* doctor intervenes with your healthcare there is a risk of side effects and complications. Research has shown that the risk of serious complications from chiropractic treatment is ***extremely rare***. While less serious complications are possible, most are highly unlikely, but could include fractures, sprains/strains, injury to intervertebral discs, nerves, spinal cord, a worsening of symptoms or development of new symptoms. Cerebrovascular accident such as a stroke is highly sensationalized by the media, but real research proves that it is very rare, with odds calculated as one in a million to one in forty million, about the same odds of a stroke from having your hair washed in a salon ("beauty parlor syndrome"), and significantly less than the odds of being struck by lightning. Usually, side effects of treatment include transient muscular stiffness or soreness; some people report feeling like they exercised new muscles for the first time. Some procedures (e.g. hot packs or deep tissue massage) could produce skin irritation, burns or bruises. Keep in mind that other treatment options such as over-the-counter analgesics, prescription medicines, surgical procedures, and hospitalization all carry ***significant*** risks and side effects, greater than those encountered in a chiropractic office.

Risks of remaining untreated: While it is possible that your symptoms may go away without any treatment whatsoever, delay of treatment could complicate recovery, lead to worsened or chronic pain, or deteriorate your health.

I have read the above explanation regarding chiropractic treatment. I have had the opportunity to have questions answered to my satisfaction. I freely decide to undergo the recommended treatment, and hereby give full consent to treatment. A photocopy of this document is considered as effective and valid as the original for any successive services.

_____

Patient name

_____ _____

Signature of patient or parent / legal guardian Date

251 West Central Street, Suite 6, Natick, MA 01760 (P) 508-650-1091 (F) 508-650-1563 www.drgillman.com

New Patient History Date File

Full name_____ Nick name _____ Age _____

Marital status: M S W D Children? (# and ages): _____

Occupation:_____ Are you ☐ right-handed ☐ left-handed ☐ ambidextrous

How is most of your day spent? ☐ standing ☐ sitting ☐ walking ☐ lifting/carrying

Have you ever been to a chiropractor? ☐ no ☐ yes When & Why?:_____

Any previous vehicle crash injuries? ☐ no ☐ yes When?_____

Have you ever suffered a work-related injury? ☐ no ☐ yes When?_____

What complaint or issue brought you here? When did it begin? How long have you had it?

_____

_____

_____

_____

Have you had an MRI, CT scan or X-Rays for this condition? no ☐ yes ☐ When/Where? _____

Is your condition ☐ improving? ☐ worsening? ☐ not changing? Does pain wake you from deep sleep? ☐ no ☐ yes

Who is your primary care physician? _____

Have you seen any other healthcare providers (MD, PT, LMT, L.Ac, etc.) for this current complaint/issue? ☐ no ☐ yes

Please elaborate:

Describe each problem or painful body region separately (e.g.: #1: headaches, or #2: lower back pain).

Problem Area #1:_____

Are symptoms constant? ☐ Do they come & go? ☐ Rate pain from 0 (none) to 10 (unbearable): 0 1 2 3 4 5 6 7 8 9 10

What provokes your symptoms? _____ What alleviates them? _____

Problem Area #2: _____

Are symptoms constant? ☐ Do they come & go? ☐ Rate pain from 0 (none) to 10 (unbearable): 0 1 2 3 4 5 6 7 8 9 10

What provokes your symptoms? _____ What alleviates them? _____

Problem Area #3: _____

Are symptoms constant? ☐ Do they come & go? ☐ Rate pain from 0 (none) to 10 (unbearable): 0 1 2 3 4 5 6 7 8 9 10

What provokes your symptoms? _____ What alleviates them? _____

Today's Date: _____ Patient: _____ File:_____

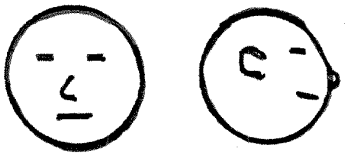
CIRCLE, MARK, COLOR-IN OR IDENTIFY AREAS OF YOUR BODY THAT HAVE A PROBLEM.

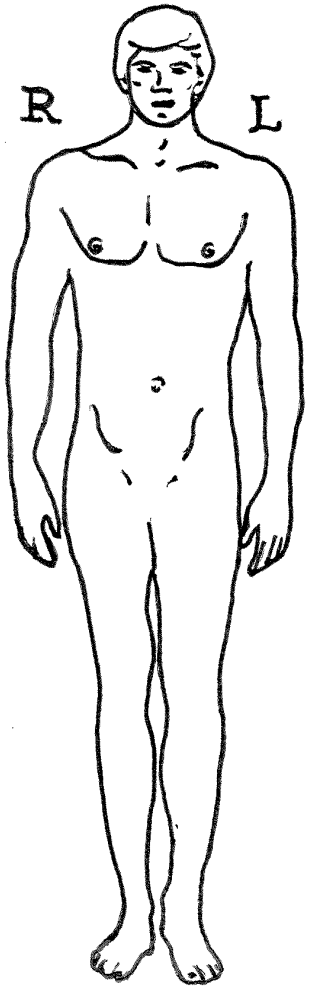
Feel free to use the symbols in the box below to describe the type(s) of pain or sensations you experience.

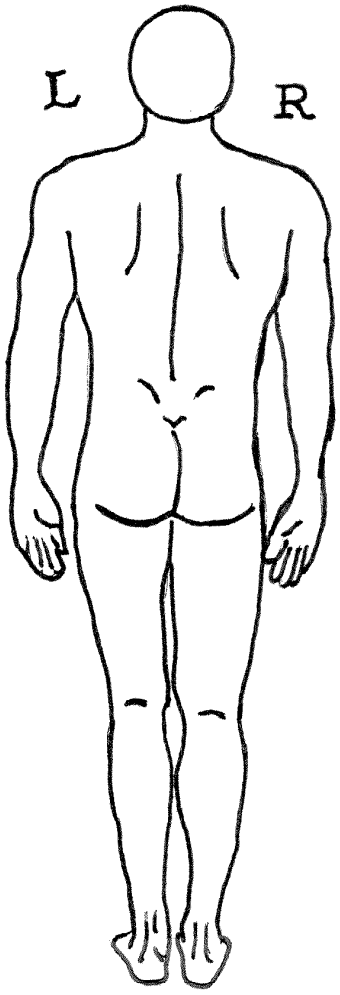
>>>	**Aching Pain**
XXX	**Burning Pain**
===	**Numbness**
OOO	**Pins & Needles**
////	**Stabbing Pain**

FOR FACE OR HEAD PAIN:

☐Rt Side ☐Lt Side ☐ Both







What have you been treated for in the past?

☐ Back pain	☐ Concussion	☐ Irritable bowel	☐ HIV +	☐ Nervousness
☐ Neck pain	☐ Struck unconscious	☐ Digestion problem	☐ Hepatitis	☐ Depression
☐ Numbness/tingling	☐ Eye injury	☐ Heart problem	☐ Mononucleosis	☐ Anxiety
☐ Sciatica	☐ Sinus problems	☐ Kidney problem	☐ Anemia	☐ Addiction/dependency
☐ Jaw pain/TMJ	☐ Shortness of breath	☐ Thyroid problem	☐ Excessive thirst	☐ Eating disorder
☐ Headaches	☐ Dizziness/vertigo	☐ Liver problem	☐ Night sweats	☐ Difficulty breathing
☐ Shoulder pain	☐ Chest pains	☐ Gall Bladder Problem	☐ Significant weight loss	☐ Asthma
☐ Elbow/arm	☐ High blood pressure	☐ Lung disease	☐ Frequent urination	☐ Benign lumps or tumors
☐ Carpal tunnel synd.	☐ Arteriosclerosis	☐ Menstrual irregularity	☐ Diabetes	☐ Cancer (describe below):
☐ Knee problems	☐ Constipation	☐ Menstrual cramps	☐ Limb edema	
☐ Foot/ankle	☐ Sleep disorder	☐ Prostate problem	☐ Bruise easily	
☐ Tendonitis/bursitis	☐ Fractures	☐ Uterus/ovary problem	☐ Chronic fatigue	
☐ Sprained ankle(s)	☐ Osteoporosis/penia	☐ Skin diseases	☐ Lyme disease	

☐ **No known allergies** **IF ALLERGIC, CIRCLE ALL THAT APPLY**:

Insect/bee Stings Latex Sulfa drugs Penicillin Food dyes Eggs Milk/dairy Peanuts Tree nuts

Fish Shellfish Soy Molds Dusts Pollens Pet dander **Other allergies**: _____

List all surgeries and hospitalizations. Do you have any residual issues from surgery?

_____

_____

_____

List all medicines, herbs/vitamins you currently take (attach or email a list if you prefer).

_____

_____

Social history:

Are you a smoker? ☐ no ☐ yes: How much ? _____

Past smoker? ☐ no ☐ yes: Quit what year ? _____

Consume alcohol? ☐ daily ☐ weekly ☐ seldom ☐ never

Caffeine drinks/day ☐ 4-6/d ☐ 2-3/d ☐ 1-2/d ☐ seldom/never

Are you using any other substance not prescribed to you? ☐ no ☐ yes

List your family medical history:

e.g. arthritis, hip replacement, cancer, diabetes, stroke, heart ds, neurologic ds,

Mother:

Father:

Sibling(s):

Do you have a regular exercise or sports regimen? ☐ no ☐ yes If yes, what and how often?

_____

_____

Were you very active in any particular sports when you were younger (e.g. high school track, college football, ballet)?

_____

Patient (or Parent/Legal Guardian) Signature:_____ Date:_____

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OFFICE POLICIES OF THE GILLMAN CHIROPRACTIC OFFICE

PERMISSION TO COMMUNICATE (HIPPA)

I authorize and give permission to Gillman Chiropractic and their staff and/or associates to communicate with me by regular mail, email, phone calls to my home, work, wireless phone, or answering machine(s). I understand that communication will be in regard to appointments, clerical issues and clinical issues. I understand that due diligence will be employed in being discrete about any clinical issues conveyed via the above modes of communication. I understand that I have the right to refuse certain types of communication by notifying Gillman Chiropractic or their staff in writing.

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION (HIPPA)

I hereby authorize Gillman Chiropractic or their assigned staff members to release information contained in my medical record to any and all insurance carriers from whom I may be due benefits, to my primary care physician or other healthcare providers associated with my treatment, to the state chiropractic society in the event their assistance is needed on my behalf, and to my attorney of record (if an attorney is involved).

ASSIGNMENT OF PROCEEDS

Under Massachusetts Law, Chapter 106, Section 9-109(C)(8) and 9-315(C), I hereby instruct and direct that payments for my services be sent directly to the Gillman Chiropractic Office and not to me, my guardians, my estate, or my attorney, regardless of any assignment of benefits my attorney or others may present on my behalf, and regardless of the date such other assignment or instruction may be signed by me or presented by others.

- I hereby instruct and direct that payments for health care provided me by any member of the office of Gillman Chiropractic, as reflected in bills for such service that they may present, as may be due me under terms of a contract of health insurance, or as a result of an action at court, settlement, structured settlement, judgment, verdict or arbitration award which I may receive or be due, be sent directly to the office of Gillman Chiropractic. This instruction shall be considered irrevocable, and shall survive me, and my period of care with the office of Gillman Chiropractic forever and without exception.
- Regarding only payments for Gillman Chiropractic's services to me as reflected in bills they present; I hereby rescind any and all assignments of benefit presented by my attorney of any date prior to this date to any party receiving this notice.

- Also, under all circumstances, I direct and instruct that any monies sent to any party as payment for the services at the Gillman Chiropractic office, following receipt of office bills and or statements, BE MADE PAYABLE SOLELY TO GILLMAN CHIROPRACTIC.

COLLECTION POLICY AGREEMENT

- I hereby acknowledge that any health insurance coverage benefits information given to me is a courtesy and I acknowledge that I am ultimately responsible for knowing my own health insurance coverage benefits. I hereby acknowledge that any insurance benefits quoted to me at the time of treatment is not a guarantee of payment by my health insurance company, and that Gillman Chiropractic is not responsible for any health insurance information given.
- I hereby acknowledge that I am ultimately fully responsible for the payment of all charges or fees for services provided me regardless of any contract of insurance, any action at court, any settlement, structured settlement, judgment, verdict or arbitration award which I may receive or be due, or the course or outcome of any dispute regarding same. I also understand that I may be charged a $5 monthly late fee for any patient balances unpaid after 30 days.
- I agree to deliver to Gillman Chiropractic any check, draft or funds that I receive from any source intended as payment for services rendered me by Gillman Chiropractic within 10 calendar days of receipt by me and to be responsible for a $5 monthly late fee for failure to deliver money before 30 days.
- I agree to reimburse Gillman Chiropractic for all reasonable collection costs he incurs that arise from collection actions they take against me in the process of settling my account.
- In the event a personal check is returned to Gillman Chiropractic, I hereby agree to pay in full the original check amount, Bank fee(s), and a processing fee of $25 per each returned check. I hereby acknowledge that a personal check may not be used to satisfy this obligation.
- We reserve the right to charge an administrative fee for any account that requires staff resources beyond normal insurance requirements as determined by Gillman Chiropractic, PC.

APPOINTMENT POLICY

We reserve the right to charge a $60 fee for appointments that are blatantly missed or appointments that are cancelled without notice of at least four (4) hours. The $60 fee is your bill, not your insurance company's bill.

A photocopy of this document is considered as effective and valid as the original for any successive services. I acknowledge that I received these HIPAA and office policies and have read, understood and agreed to them per my signature: below.

Signature: _____ Date: _____

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SECURE EMAIL NOTIFICATION / WAIVER

In order to comply with the Federal HIPAA Security Rule, our office has implemented the use of a secure, encrypted email program (Sendinc.com) to send and receive email which contains **protected health information** (PHI).

Secure email can easily be sent to us by going to this web site or through our patient portal (Patient Ally). To send and receive email requires you to register and create a password. **Note:** You must be sure to **check your Junk Mail or Spam** folder as some patients report that the secure email goes directly to those folders instead of the inbox. We recommend you open and save documents immediately as **Secure Email** will automatically be deleted (made inaccessible) after 7 days if not opened.

Some of our patients have requested to use standard (non-secure) email even though there is a risk that their PHI will no longer be private or protected and may become public information or used for insurance fraud or identity theft if the email system is hacked at either end.

It is your right to request to have your correspondence sent via standard email. However, if you choose this option, you must acknowledge that you were informed of, understand, and accept the risks of using non-secure email for patient communication containing PHI.

PLEASE CHECK ONE BOX ONLY

☐ **I choose to use Secure Email (Sendinc.com) for email correspondence containing PHI.**

☐ **WAIVER: The provider has explained to me and I fully understand the risks associated with using standard email for correspondence which contains protected health information (PHI). I hereby acknowledge and accept those risks and request that my email correspondence be sent via standard (non-secure) email.**

A photocopy of this document is considered as effective and valid as the original for any successive services.

_____

Signature of patient (or guardian of a minor)

_____ _____

Patient Name (PLEASE PRINT) **Date**

The following Authorization for Release of Medical Records form is used throughout the course of your care in this office when we must obtain records from other facilities. Please just sign the form and leave all other areas blank. This signed form will be re-used whenever records are needed. Information will be completed when and where records are needed. This enables us to save paper and time when multiple record requests are needed.

Authorization for Release of Medical Records To Dr. Scott F. Gillman

I hereby authorize _____ to use or disclose the following protected health
Name of Physician / hospital

information from the medical records of the patient listed below. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may

not be subject to federal or state law protecting its confidentiality.

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

THIS AUTHORIZATION OR PHOTOCOPY HEREOF DIRECTS HEALTHCARE FACILITY/PROVIDERS TO RELEASE ANY OR ALL INFORMATION REQUESTED VIA PHONE OR MAIL.

Information to be disclosed to: Gillman Chiropractic, PC
251 West Central Street
Natick, MA 01760
(Phone) 508-650-1091, (Fax) 508-650-1563

Disclose the following information for treatment dates: _____ to _____

Complete Records Xray Reports Xray Films MRI Reports

Other Specified: _____

The above information is disclosed for the following purposes: **MEDICAL/ HEALTHCARE**

I understand that I may refuse to sign or may revoke (at any time) this authorization for any reason and that such a refusal or revocation will not affect the commencement, continuation or quality of my treatment at the offices of Dr. Scott F. Gillman; except, however, if my treatment at the offices of Dr. Scott F. Gillman is for the sole purpose of creating health or obtaining information for disclosure to Dr. Scott F. Gillman then he may refuse to treat me if I do not sign this authorization.

I understand that the Authorization will remain in effect until the term of this Authorization expires or until I provide a written notice of revocation to Dr. Scott F. Gillman at the address listed above. The revocation will be effective immediately upon Dr. Scott F. Gillman's receipt of my written notice, except that the revocation will not have any effect on any action taken by the offices of Dr. Scott F. Gillman in reliance on this Authorization before it received my written notice of revocation.

This authorization will be valid for 90 days from the signature date, or until _____.

I have read and understand the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize the above -mentioned physician/hospital to disclose my health information in the manner described above. A photocopy of this document is considered as effective and valid as the original for any successive services.

_____
Patient Signature

_____ _____
Printed name of patient or patient's representative **Patient File Number**