Information about Possible Risks of Treatment

Doctors of Chiropractic, Medical Doctors, and Physical Therapists using manual therapy treatment for patients with headache and cervical spine (neck) complaints, are required to explain that there have been rare cases of injury to a vertebral artery as a result of treatment. Such an injury has been known to cause a stroke, sometimes with serious neurological damage. The chances of this happening are estimated to be approximately 1 per 400,000 to 1 per 2 million treatments.

*Appropriate tests will be performed to help identify if you may be susceptible to this type of injury; you will be notified if that is the case. If you have any questions about this, please do not hesitate to speak with your Doctor of Chiropractic.

*As with any health procedure, complications may arise during treatment. These complications include soreness, muscle or ligament strain, dislocations, fractures, disk injuries of physiotherapy burns. These are extremely rare occurrences.

_____	_____	_____
Signature of Patient or Responsible Party	Date	Relationship to Patient

Explanation of Medicare coverage:

Medicare covers 80% of your spinal adjustment. They will not cover Examinations, Ultrasound therapy, X-rays, Extremity adjustments (ex: arm, knee, elbow) or Acupuncture.

If you have a second insurance, most will cover the remaining 20% of your spinal adjustment. In most cases, they will not cover Examinations, Ultrasound therapy, X-rays, Extremity adjustments, or Acupuncture.

Signed:_____**Date:**_____

Lecy Chiropractic, P.C.
Patient Information Sheet

Name _____
First Middle Initial Last Preferred Name

Address: _____
Street City State Zip

Select Race:
❍ Caucasian ❍ African American ❍ Native American ❍ Asian ❍ Hispanic
❍ Other_____

Sex: ❍ M ❍ F Date of Birth: _____ Social Security #: _____

Home Phone: _____ Work Phone: _____

Employer: _____ Occupation: _____

❍ Married
❍ Single
❍ Divorced
❍ Widowed

Work Address: _____
Street City State Zip

Email Address: _____

Spouse or Parent's Name _____ Date of Birth: _____

Referred to this office by: _____

Area of Complaint: ❍ Neck ❍ Upper Back ❍ Lower Back ❍ Other: _____

Mark the appropriate coverage: ❍ Cash ❍ Insurance ❍ Medicare ❍ Medicaid/Title 19
❍ Automobile Accident ❍ Worker's Comp ❍ Personal Injury

PAYMENT POLICY

It is the policy of this office that payment be made at the time of service for all services rendered. If desired, please ask for an estimate of fees before beginning treatment. If you are unable to pay at the time of your visit, please talk with the receptionist to make financial arrangements. I have read the above policy, and agree that I am financially responsible for all charges incurred at this clinic. **Initials**_____

INSURANCE ASSIGNMENT

We will automatically submit your insurance claims to your primary carrier, unless other arrangements are made. I hereby instruct and direct my insurance company to pay, by check made out and mailed directly to Lecy Chiropractic, P.C., the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered by this clinic. A photocopy of this assignment shall be considered as effective and valid as the original. **Initials**_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice of privacy practices is available at front desk upon request. **Initials**_____

TELEPHONE CALLS

According to HIPAA policy, Lecy Chiropractic, P. C. must have your permission to call your home. Please initial if you give the doctors and staff of Lecy Chiropractic, P. C. permission to call your home regarding your health or appointments. **Initials**_____

Signature of Patient or Parent/Guardian _____ **Date** _____

Lecy Chiropractic, P.C., 1406 Mt. Rushmore Road, Rapid City, SD 57701, (605) 343-7440, FAX 342-7868

HIPAA Approved Contacts

Please list the individuals you give permission to have access to and discuss your protected health information:

NAME	Date of Birth	Phone #	Relationship
_____	___/___/___	(___) ___ - ___	_____
_____	___/___/___	(___) ___ - ___	_____
_____	___/___/___	(___) ___ - ___	_____
_____	___/___/___	(___) ___ - ___	_____

This form will remain in effect until a written request is received to change or an updated form is filled out by you.

_____ _____

Patient/Legal Guardian Signature Patient Name

_____

Date