Glesener Chiropractic Center, P.C. dba Fox Valley Chiropractic Physicians
CONSENT TO CHIROPRACTIC EXAMINATION AND CARE

PATIENT NAME:_____ DATE_____

To the patient: As a patient, you are entitled to be informed the purpose, benefits, and potential risks of a health care procedure, and to make the decision about whether or not to undergo the procedure. **Please read this entire document prior to signing it. It is important that you understand the information contained in this document. In anything is unclear, please ask questions before you sign.**

The Nature of the Chiropractic Adjustment

A primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy (also called "chiropractic adjustment"). If I believe it is indicated in your case, I will use this treatment by placing 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.

Other Examinations, Tests and Treatments

In addition, I may use other tests and examinations, some of which are listed below, if I believe they are warranted based on your condition and the information you give me. As a part of the analysis, examination, and treatment, you are consenting to the following procedures, except those that you initial below:

spinal manipulative therapy
palpation
vital signs
range of motion testing
orthopedic testing
basic neurological
Graston Fascial Manipulation
postural analysis
manual therapies
ultrasound
hot/cold therapy
electrical muscle stimulation

Material Risks Of Chiropractic Adjustment

As with any healthcare procedure, certain complications 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 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.

Probability of 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. In 2008, one study reported the risk to be 1 case per 400,000 to 1,000,000 cervical spine adjustments. To the best of my knowledge, this is the largest controlled research study to date on this issue. Please ask if you would like additional information regarding cervical spine adjustments and risk of stroke. The other complications are also generally described as rare.

Availability and Nature of Other Treatment Options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest – risks may include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers - typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- Hospitalization -- risk of exposure to infection and/or communicable disease in a significant number of cases.
- Surgery -- risk of adverse reaction to anesthesia, as well as an extended recovery period in a significant number of cases.

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If you choose to use one of the above noted "other treatment" options, you should discuss their risks and benefits with your primary medical or osteopathic physician.

Risks of Remaining Untreated
Delay of treatment may allow formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. Therefore, delay of treatment may complicate the condition and make future rehabilitation more difficult.

Other Procedures and Risks: I have recommended that you undergo the following procedure (not listed above):

_____

I have fully explained to you the risks and benefits of undergoing this procedure, as well as the risks and benefits of declining to undergo this procedure.

Risk of COVID-19
The World Health Organization has declared COVID-19 to be a pandemic, the first to be caused by Coronavirus. This office follows all CDC-recommended steps for infection control, including appropriate staff and patient screening (e.g., temperature, cough, breathing difficulties, recent travel, any exposure to COVID-19); all cleaning/disinfecting protocols; and social distancing requirements. However, even strict adherence to these procedures cannot guarantee the complete absence of the Coronavirus in my office (or in any location), nor can it guarantee that Coronavirus transmission will never occur. Please ask if you have any questions regarding our infection control procedures. By signing this form, you acknowledge our infection control procedures and understand that this office cannot completely eliminate the risk of exposure to COVID-19 on our premises.

For Parent or Guardian Signing Form on Behalf of Patients Under 18 Years of Age
This office observes all laws regarding a minor patient's right to consent to, and to confidentiality of, his or her health care treatment. In addition, this office follows a policy of transitioning adolescent patients to self-management of their own health. We view our office visits as an opportunity for your child to learn to take responsibility for their health care. Therefore, as appropriate by age and maturity of the patient, parents may be asked to excuse themselves for a portion of or the entire health care visit. By signing this form, the parent or responsible party acknowledges understanding of and consent to this policy.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THIS FORM.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW:
I have read [Consent to Chiropractic Examination and Care] or have had read to me [Consent to Chiropractic Examination and Care] the above explanation of the chiropractic adjustment and related treatment, as outlined in this document. I have discussed it with Dr. Mark Glesener and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks and benefits involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. I understand that the doctor will use his or her best professional judgment but cannot and does not guarantee any outcome or results. Having been informed of the risks, I hereby give my consent to treatment as outlined in this document.

Dated: _____

_____
Patient's Name (print)

Glesener Chiropractic Center, P.C.
Dba: Fox Valley Chiropractic Physicians

_____
Signature of Patient

_____
Representative Signature

OR

_____
Signature of Responsible Party
(Parent or Guardian)

_____
Responsible Party's Relationship to Patient

Patient Intake Form

Patient Information

Full Name: _____ Date: _____
First MI Last

Address: _____ City: _____ State: _____ Zip: _____

Age: _____ Birth Date: _____ Female: _____ Male: _____

Email Address: _____

Home Phone: _____ Work Phone: _____ Cell: _____

I prefer to receive calls at Home/Work/Cell I am Under Age18/Single/Married/Divorced/Widowed/Separated

Employer: _____ Occupation: _____
Spouse's Name: _____
Emergency Contact: _____ Phone Number: _____

Who referred you to our office? _____
What condition brings you to our office? _____
_____
_____

Payment Information

Person Responsible for Payment: _____
Phone: _____ Date of Birth: _____

Insurance Information

Do you have health insurance? ____ Yes ____ No

Primary Insurance	Secondary Insurance
Insurance Company:	Insurance Company:
Policy Holder's Name:	Policy Holder's Name:
Relationship to Patient:	Relationship to Patient:
Policy Holder's Birth Date:	Policy Holder's Birth Date:
Group Number:	Group Number:
Policy ID Number:	Policy ID Number:

Please have your insurance card and driver's license ready so they can be copied for the clinic's records.

Consent for Treatment

Assignment & Release *- By signing below, I authorize [clinic name] to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to [clinic name] and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.*

By signing below, I give my consent for examination and the performance any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient

Signed _____ Date _____

CASE HISTORY

Please answer the questions below concerning your health history. Be sure to list all conditions or symptoms, both past and present.

An understanding of your health history will help us to determine appropriate care.

FULL NAME_____ **DATE**_____
AGE_____ **RACE**_____ **GENDER**_____ **HEIGHT**_____ **WEIGHT**_____

Review of Systems

1. Do you have skin, hair or nail problems: ☐ Yes ☐ No _____
2. Do you have mouth and/or throat problems? ☐ Yes ☐ No _____
3. Do you have nose and/or sinus problems? ☐ Yes ☐ No _____
4. Do you have ear problems? ☐ Yes ☐ No _____
5. Do you have eye problems? ☐ Yes ☐ No _____
6. Do you have chest or lung (breathing) problems? ☐ Yes ☐ No _____
7. Do you smoke? ☐ Yes ☐ No Amount per day_____ How long?_____
8. Do you have heart and/or blood vessel problems? ☐Yes ☐ No _____
9. Do you have blood or lymph node problems? ☐Yes ☐No _____
10. Do you have digestive problems? ☐Yes ☐No _____
11. Do you have genital problems (e.g. prostate, testicular, vaginal)? ☐Yes ☐No _____
12. Do you have urinary (including kidney or bladder) problems? ☐Yes ☐No _____
13. **Females,** have you had menstrual problems? ☐Yes ☐No _____
    Have you ever taken birth control? ☐Yes ☐No For how long?_____
    Is there any chance that you are currently pregnant? ☐Yes ☐No
    Do you have any breast problems? ☐Yes ☐No _____
14. Do you have any nervous system diseases and/or mental health problems? ☐Yes ☐No _____
15. Do you have any gland and/or hormone problems? ☐Yes ☐No _____
16. Do you have allergy or immunity problems? ☐Yes ☐No _____
17. Do you have any muscle, tendon or ligament problems? ☐Yes ☐No _____
18. Do you have any bone or joint disease (examples: bone=osteoporosis, joint=arthritis)? ☐Yes ☐No

Past History

21. Have you suffered any physical injuries such as falls or blows, automobile accidents, whiplash, concussion or head injury, lacerations, sprains, strains, dislocations, broken or cracked bones? ☐Yes ☐No
22. List any surgeries since your last visit (don't forget appendix tonsils, ear tubes, wisdom teeth):
    _____ Date_____
    _____ Date_____
    _____ Date_____
    _____ Date_____
    _____ Date_____
23. Have you had any hospitalizations since your last visit? ☐Yes ☐No_____
24. **Medications:** Please list all medications (prescription & non-prescription) you are currently taking or take on an occasional basis:_____
25. Your diet is: ☐ Balanced ☐ Fair ☐ Poor ☐ Excessive ☐Restricted

(OVER PLEASE)

FULL NAME_____ DATE_____

Family History

26. Are there any diseases or conditions that are common among your family members (i.e. inherited diseases or conditions)? ☐Yes ☐No_____

Social History

27. In what position do you usually sleep, and how well?_____
28. Do you exercise on a regular basis? ☐Yes ☐No How?_____
29. How do you spend your spare time (hobbies, etc)?_____
30. Do you use: ☐ Caffeine? ☐Tobacco? ☐Nicotine? ☐Recreational Drugs? ☐Alcohol?
31. Please describe your work:
    Type: ☐Professional ☐ Physical Labor ☐ Driver ☐ Clerical ☐ Factory ☐ Homemaker
    Physical Demands: ☐ Heavy ☐ Moderate ☐ Mild ☐ Sedentary
    Stress Level: ☐High ☐Medium ☐Low

Additional Questions

32. Do you have problems with recurring headaches? ☐Yes ☐No_____
33. Are you losing weight without trying? ☐Yes ☐No
34. Does your pain wake you up at night? ☐Yes ☐No
35. Have you had a change in bowel or bladder habits? ☐Yes ☐No_____
36. Have you had a sore that doesn't heal? ☐Yes ☐No_____
37. Have you recently had any unusual bleeding or discharge? ☐Yes ☐No_____
38. Do you have a thickening/lump in the breast or elsewhere? ☐Yes ☐No_____
39. Do you have indigestion or difficulty swallowing? ☐Yes ☐No_____
40. Have you had an obvious change in a wart or mole? ☐Yes ☐No_____
41. Do you have a nagging cough or hoarseness? ☐Yes ☐No_____
42. In the space below, please explain or give additional details regarding the information n you have given above. Also, if there is any information about your health history which was not requested, please fill it in below.
    _____
    _____
43. Please describe your current complaint. In other words, what brought you here?_____
    _____
    _____
44. Who is your:
    Medical Doctor?_____
    OB/GYN?_____
    Dentist?_____

ASSIGNMENT OF BENEFITS
-IRREVOCABLE-

In consideration of your undertaking to render care, I agree to the following:

Release of Information

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me at your treatment facility.

Right to Receive Payment

2. I authorize and assign to you, the medical provider, the right to receive direct payment from my attorney or any insurance company who may become obligated to pay me any sums. I further authorize the endorsement of my name to any draft or check containing my name to which you are legally entitled.

Assignment of Right to Sue

3. In the event any insurance company or attorney, obligated by contractual agreement to issue payments to me for your service charges, refuses to pay upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company or attorney and authorize you to prosecute said action either in my name or your name as you otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from said insurance proceeds (whether it be all or part of what is due) shall be paid by me.

4. I also assign to you, the medical provider, and grant the right of lien against any and all claims against any third party, whose negligence may have caused my injury, including their insurance, up to the amount of the bill for treatment.

5. I waive the Statue of Limitations regarding my doctor's right to recover from me directly.

6. I hereby direct my attorney to cooperate, assist and not interfere with you, the medical provider, in recovering any MedPay benefits that I may be entitle to.

PATIENT:_____ DATE:_____

PATIENT SIGNATURE:_____

MEDICAL PROVIDER: MARK J. GLESENER, D.C.

FOX VALLEY CHIROPRACTIC PHYSICIANS

Glesener Chiropractic Center, P.C.
1750 E. Main Street, Suite 60, St. Charles, IL 60174
630-377-8844

ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, _____, have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.

Obtain payment from third-party payers.

Conduct normal health care operations such as quality assessments and accreditation.

_____
Patient

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

- ☐ **Individual refused to sign**
- ☐ **Communications barriers prohibited obtaining the Acknowledgment**
- ☐ **An emergency situation prevented us from obtaining Acknowledgment**
- ☐ **Other (Please Specify)** _____

_____

_____
Staff signature **Date**