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Patient Polices and Procedures

INFORMED CONSENT TO CHIROPRACTIC CARE PLAN

Patient Name

Please discuss any questions or conditions with the Doctor before signing the consent.

I hereby request and consent to the performance of chiropractic adjustments and the other chiropractic procedures including various modes of physical therapeutic modalities and diagnostic x-rays by the doctor or chiropractor(s) named above.

I have had the opportunity to discuss with the doctor and/or with other office or clinic personnel the purpose and the benefits of the chiropractic adjustment and other treatments outlined below. Alternatives to treatment have been reviewed.

Though chiropractic adjustments and treatments are usually beneficial and seldom cause any problem. I understand and am informed that there are some risks to treatment. Risk include, but are not limited to: fracture, disc injuries, strokes, dislocations and sprains.

I understand and agree to receive the following treatment protocol as needed:

TREATMENT (S):

- Hot/Cold Fomentation 97010
- Electrical Stimulation 97014
- Ultrasound 97035
- Mechanical Traction 97012
- Spinal Manipulation 1-2 Regions 98940
- Spinal Manipulation 3-4 Regions 98941
- Spinal Manipulation 5 Regions 98942
- Ex-Spinal Manipulations 98943
- Manual Therapy 97140
- Paraffin Bath 97018
- Infrared Therapy 97026
- Massage Therapy 97124
- Neuromuscular Re-Ed Therapy 97112
- Therapeutic Activities 97110
- Therapeutic Procedures 97530
- Self-Care Home Management 97535

TREATMENT GOALS: Reduce symptoms, Increase functional capacity and Return to ADL

- **Therapeutic Phase 1**: Acute inflammatory, reduce inflammation, muscle spasm and pain
- **Therapeutic Phase 2:** Repair and Re-mobilization; functional scar formed and increase pain free ROM
- **Therapeutic Phase 3:** Remodeling and Rehab; increase coordination and strength, endurance and

work capacity

ADJUSTMENT AREAS

C_____ T_____ L_____ S_____ IL_____ Ext_____

Treatment Frequency and Duration: Will vary according to my condition and ability to heal as much as my body will alow.

Exp. Total # of treatments approximately 30

I understand that chiropractic is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the chiropractic treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

May 9, 2025

Signature of Patient, Guardian, or Personal Representative Date

Please print name of Patient or Personal Representative

Relationship to Patient

PAIN 2 WELLNESS CENTER POLICIES AND PROCEDURES:

1. Please sign in on our sign-in sheet.

2. Fill out the patient progress report as instructed and place the document in the designated area.

3. Hours of operation are Monday thru Friday 9:15 AM till 6:30 PM and Saturday 10:00 AM till 12:00 PM (by appointment only). Please hold your preferred treatment time; we request that all appointments be made **2 weeks** in advance whenever possible. This will save you and the office time and eliminate waiting.

4. All new problems, re-exams, consultations, and diet and exercise programs are to be discussed during extended treatment hours, not during your preferred treatment time. If a new problem develops, an accident occurs, etc. you should call and reschedule an appointment from preferred hours to extended hours when more time would be available.
5. Our office accepts payment by the week (first day of your treatment/week), month, or year. Payment

each visit would cause our patients to make out unnecessary checks and cause waiting to occur.

6. Your RESULTS are obtained based on the number of **visits/week** not per month. Therefore, it is vital you hold to your schedule. If an emergency arises, we ask you to notify us as soon as possible. An official make up appointment will be assigned and reserved for you so that you can know in advance when to make up a missed appointment.

7. If you request us to direct bill your insurance company, we ask you to **leave a credit card** on account to cover our costs in the event you should receive the insurance check for our services. The credit card would only be used if you fail to provide our office with the funds within 5 days of receiving them.

PROPER PATIENT SCHEDULING PROCEDURE:

1. Reduce Waiting Treatment Hours: TREATMENT ONLY
2. Consultation/Examination Hours: Report of Findings, New Patient Examinations, Re-Evaluations, Reassessments.
3. Advanced Treatment Hours: As needed for none responding to care patients (there will be extra charge for these patients.).

By signing below I understand and agree to the patient policies and scheduling procedures.

May 9, 2025

X

Signature Certificate

Document name: Patient Polices and Procedures

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