DEINES
CHIROPRACTIC CLINIC

Informed Consent

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment:

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use 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.

Analysis/Examination/Treatment As part of the analysis, examination, and treatment, you are consenting to the following procedures: __Spinal manipulative therapy __palpation __vital signs __Range of motion testing __orthopedic testing __basic neurological testing __muscle strength testing __postural analysis testing __hot/cold therapy __EMS __radiographic studies __other

The risks inherent in chiropractic adjustment:

As with any healthcare procedure, there are certain complications which 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. The Doctor 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 the Doctor's attention it is your responsibility to inform the Doctor.

The probability of those risks occurring:

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and x-ray. Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

The availability and nature of other treatment options:

Other treatment options for your condition may include:

- Self-administered, over the counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization or Surgery

If you chose to use one of the above noted "other treatment" options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

CONSENT TO TREATMENT (MINOR)

I hereby request and authorize Dr. Deines to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter: _____. This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this ca[redacted]should be revoked or modified in any way, I will immediately notify this office.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have had any questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Signature _____ Date 7-18-2023

Patient's Name (Print) _____ Signature of Parent or Guardian (if a minor) _____

INITIAL CARE PLAN

Insurance

[redacted] Chiropractic
[redacted]-673-5075
1821 S. Sheridan Ave
Unit [redacted]
[redacted] W[redacted]

Patient: [redacted] **DOB:** 12/12/[redacted]

DATE: [redacted]

INITIAL CARE TREATMENT PLAN:

4x/week for _____ weeks = _____ visits

3x/week for _____ weeks = _____ visits

2x/week for 12 weeks = 24 visits

1x/week for _____ weeks = _____ visits

Total Visits: 24

YOUR BALANCE

Initial & Wellness Care: $ 2808.80

This value represents the patient's financial responsibility after insurance and any care not covered by your policy. We may bill you for any outstanding balance beyond this or credit your account if an overpayment occurs. For your convenience, all financial arrangments are made before your care plan begins.

PAYMENT ARRANGEMENT

Premium Package:

☐ **PAY IN FULL** $ 2114

☐ 12 Payments $ 196

on the _____ of the month

Initial Care Treatment Plan **PLUS** 32 **Wellness Adjustments**

Please Note:

- Any discounts given are based on completion of recommended initial and/or wellness care. Your results with your problem are based on your following through. Only start if you plan on completing all visits based on the chiropractor's recommendation.
- This office specializes in addressing vertebral subluxation. We are not responsible for the diagnosis or 'treatment' of medical conditions outside the scope of chiropractic.
- Regardless of any third-party arrangements please know you are responsible for your bill.
- If care ends prematurely, you are only responsible for the charges you have accrued up until that point at the clinic fee charge.
- We might use your name or photo during the normal course of business.
- All prices and payment plans are based on the duration of the care plan. Visits left unused will expire one month from the original care plan date unless otherwise arranged.
- All late payments will be charged a $30 late fee and a 10% late fee every month thereafter.
- Exams & X-rays within care plan (progress checks & Re-Exam) are included complimentary, but may still be submitted to your insurance policy.

☐ **I am aware that insurance checks will be sent to me, and I will bring them in and sign them over to be applied to the total cost of my care and deposited by Deines Chiropractic.** _____ **(Initials)**

PATIENT SIGNATURE: _____ **DATE:** _____

STAFF INITIAL: _____

INITIAL CARE PLAN

Insurance

Deines Chiropractic
307-673-5075
1821 S. Sheridan Ave
Unit A
Sheridan, WY 82801

[redacted] Sha[redacted] [redacted]

[redacted] [redacted] [redacted]

INITIAL CARE TREATMENT PLAN:

4x/week for _____ weeks = _____ visits

3x/week for _____ weeks = _____ visits

2x/week for 12 weeks = 24 visits

1x/week for _____ weeks = _____ visits

Total Visits: 24

YOUR BALANCE

Initial Care ONLY: $ 1496.80

This value represents the patient's financial responsibility after insurance and any care not covered by your policy. We may bill you for any outstanding balance beyond this or credit your account if an overpayment occurs. For your convenience, all financial arrangments are made before your care plan begins.

PAYMENT ARRANGEMENT

Basic:

☐ **PAY IN FULL** $ 933

☐ **Payments** $ 1036

☐ 3 Payments $ 345

☐ 6 Payments $ 173

on the _____ of the month

Please Note:

- Any discounts given are based on completion of recommended initial and/or wellness care. Your results with your problem are based on your following through. Only start if you plan on completing all visits based on the chiropractor's recommendation.
- This office specializes in addressing vertebral subluxation. We are not responsible for the diagnosis or 'treatment' of medical conditions outside the scope of chiropractic.
- Regardless of any third-party arrangements please know you are responsible for your bill.
- If care ends prematurely, you are only responsible for the charges you have accrued up until that point at the clinic fee charge.
- We might use your name or photo during the normal course of business.
- All prices and payment plans are based on the duration of the care plan. Visits left unused will expire one month from the original care plan date unless otherwise arranged.
- All late payments will be charged a $30 late fee and a 10% late fee every month thereafter.
- Exams & X-rays within care plan (progress checks & Re-Exam) are included complimentary, but may still be submitted to your insurance policy.

☐ I am aware that insurance checks will be sent to me, and I will bring them in and sign them over to be applied to the total cost of my care and deposited by [redacted] (initials)

PATIENT SIGNATURE: _____ **DATE:** _____

STAFF INITIAL: _____

INITIAL CARE PLAN

[redacted] Shalee Jones

DOB: 12/12/1997

[redacted]

CO-INS BCBS OTHER **Traction: YES NO** **Ther-ex: YES NO**

Visits on care plan: 24

Visits remaining on ins. policy : 14 **Physical Therapy visits**____
(-1 for NP)

Visits before ded. met : ___ **x Clinic Fee**____ = ____
(adjustment, traction, ther-ex)

Visits @ Co-Ins : 14 **x Clinic Fee** 81 **x** 20 **%** = 226.80
(adjustment, traction)

Ther-ex @ Co-Ins : ___ **x Clinic Fee** ____**x**____**%** = ____

Visits unpaid > max : 10 **x Clinic Fee** 81 = 810
(adjustment, traction, ther-ex)

Visits unpaid > max : ___ **x Clinic Fee** ____ = ____

Decompression : ___ **x Clinic Fee** ____ = ____

Progress Exams & X-ray: = $460

Total = 1496.80

CO-PAY BCBS OTHER **Traction: YES NO** **Ther-ex: YES NO**

Visits on care plan: _____

Visits remaining on ins. policy : _____ **Physical Therapy visits**____
(-1 for NP)

Visits with Copay : ___ **x Copay** _____ = ____
(adjustment, traction, ther-ex)

Ther-ex not included : ___ **x Copay** _____ = ____

Visits unpaid > max : ___ **x Clinic Fee** _____ = ____

Decompression : ___ **x Clinic Fee** _____ = ____

Progress Exams & X-ray: = $460

Total = _____

INSURANCE VERIFICATION

Patient Name Shalee Jo[redacted]

[redacted]

Primary Ins. Co. BCBS-WY

ID # ZBW1[redacted]6479630001

Insured Name [redacted]

Date of call 7/24/23
Time 4:00 PM

Effective Date 2/1/2023

In Network Out of Network

Calendar Year Contract Year _____

Does Ins. pay Pt or [redacted] _____

Individual Deductible $500

How much has been met? $500

Family Deductible $1,000

How much has been met? $25.33

Individual Out of Pocket _____

How much has been met? _____

Family Out of Pocket _____

How much has been met? _____

What is the Copay? _____

What is the co-insurance? 80/20

Max $ per year? _____

Max $ per visit? _____

Max visits per year? 15

Visits used? Ø

Ther-Ex Covered (97110)? Yes / No

PT Visits_____ **Used**_____

Spoke with _____

Ref #: _____

Notes: _____

_____

_____

O Verified Benefits w/ Representative

O In/Out of Network Confirmed with Rep

Staff Initials: _____

Secondary Ins. Co. _____

ID # _____

Insured Name _____

Date of call _____
Time _____

Effective Date _____

In Network **Out of Network**

Calendar Year Plan? **YES** **NO**

Does Ins. pay Pt or Office? _____

Individual Deductible _____

How much has been met? _____

Family Deductible _____

How much has been met? _____

Individual Out of Pocket _____

How much has been met? _____

Family Out of Pocket _____

How much has been met? _____

What is the Copay? _____

What is the co-insurance? _____

Max $ per year? _____

Max $ per visit? _____

Max visits per year? _____

How many have been used? _____

Ther-Ex Covered (97110)? Yes / No

PT Visits_____ **Used**_____

Spoke with _____

Ref #: _____

Notes: _____

_____

_____

O Verified Benefits w/ Representative

O In/Out of Network Confirmed with Rep

Staff Initials: _____