

Eastside Chiropractic, PA
3014 Wade Hampton Blvd.
Taylors, SC 29687
864-292-6777

A Special Message from Dr. David H. Mruz, Clinic Director

Dear Patient,

Welcome to the office! We are honored you have chosen this office to provide Chiropractic care to you and/ or your family. Be assured that we will do everything in our power to give you a very positive experience. Our aim is to get you well and help you meet *your* health goals...period. Our office mission and guarantee:

***“If we can help you, we will tell you. If we cannot help you,
We will tell you that as well and make the proper referral.”***

Notice of Privacy Practices

In accordance with the Protected Health Information Act (PHI) our office will, without asking your express consent or authorization, use and disclose your PHI for the purposes of:

Treatment

Payment

Health Care Options

Advice of Appointments and Services

Directory/Sign-In Log

Court Orders, Subpoenas and Government Investigations

Advise Family/ Friends directed by you to receive information regarding your health or to assist in the payment of your bill.

You have the right to revoke, request special limits or conditions, to receive communication by more confidential means or at alternate locations, to inspect and copy your PHI, and to amend you PHI.

Copies of the NPP may be obtained upon request. Our office strives to maintain HIPAA compliance.

I understand that by signing the above statement I have been notified of my rights in compliance with HIPAA regulations. I have been advised that I may request a complete copy of these rights available through the HIPAA officer at this location.

Signature

Date

If you ever need anything, just ask one of our staff or call me directly at 864-292-6777. I would love your feedback on how we are doing in terms of meeting, hopefully exceeding your expectations so that you will refer your friends, family, and co-workers. The greatest compliment we can receive is the trust placed in us via your referrals. We value that trust! Again, welcome to the office!

Patient Informed Consent

Congratulations on choosing chiropractic health care. This clinic believes it is the safest, most natural health care delivery system in the world today. Chiropractic adjustments (chiropractic manipulative therapy; C.M.T.) and other care procedures are safe and cost effective.

All health care professionals (anesthesiologists, chiropractors, dentists, medical doctors, osteopaths, pharmacists, surgeons,) are regulated by laws and boards. These health care professionals are required to give you, the patient, advanced notice of any care risks, because health care is not an exact science. It is not reasonable to expect any doctor to foresee all risks and /or complications. Informed consent information regarding any risks such as: paraplegia quadriplegia, brain damage stroke disc injury, breaks fractures, dislocations, drug reactions, death or loss of function of any organ or limb, or disfiguring scars associated with physical care, drugs, surgery and/or treatment is an undesirable result, but it does not necessarily indicate an error in clinical judgment. No guarantee of cure or results has been made to you, the patient in this clinic. Your care may involve the making of recommendations based upon facts known to the doctor at this time. Chiropractic care does not use drugs or surgery, and does not diagnose internal and /or medical conditions.

For your information the following is furnished to all patients who request and /or accept chiropractic care in this clinic. Again chiropractic care does not use drugs or surgery, and does not diagnose internal and/ or medical conditions. This clinic is staffed with graduate chiropractors who are licensed and recognized by government agencies regulating all the aforementioned healing arts.

Chiropractic is the science that concerns itself with the relationship between the brain, ventral nervous system, spine, and the function of the body. Any alteration of this relationship can cause the biomechanical and neuronal disturbances in the form of the vertebral subluxation complex (V.S.C) with its physical and chemical components, which can then interrupt the body's inherent recuperative powers.

The practice of chiropractic can include exams and diagnostic testing. In some cases, this includes the utilization of specialized instrumentation, lab tests, radiological exams, nutritional and /or physical therapy, and rehabilitation procedures, etc. There is a special procedure unique to chiropractic: the chiropractic adjustment (chiropractic manipulative therapy-C.M.T.). Adjustments are made by chiropractors to correct and/ or reduce and/ or stabilize vertebral or extremity subluxation complexes. The goal of chiropractic health care is to reduce and/ or stabilize the nerve interference caused by the VSC and its component parts. There are over 200 different adjusting techniques, some using specialized equipment. Adjustments are usually performed by hand-guided instruments, but may be performed by hand. A C.M.T. is the application of a specific force, applied to a segmental contact point, usually on a vertebra, to reduce or stabilize the V.S.C. and its component parts.

You should understand the benefits of chiropractic health care, but you also need to be aware of some of the limited inherent risks. These occur seldom enough to contraindicate care, but should be considered in your informed decision to receive chiropractic care.

All health care procedures have some risks. With C.M.T.'S these risks may include musculoskeletal sprain/strain, disc injuries, dislocations, fracture, neurological deficits, Homer's Syndrome, Vertebral Artery Syndrome (V.A.S.), stroke, The chances of this occurring have been

estimated by experts to be approximately only 1 per 400,000 treatments, to 1 per 1,000,000 treatments.

Appropriate tests will be performed to identify if you may be susceptible to these risks, and you will be notified, in that event. If you have any questions about these issues, please do not hesitate to speak with your doctor of chiropractic.

I have read (or have had read to me) the above information. I wish to rely on the doctor's judgment during my course of care, based on the facts then known. I have also had opportunity to ask questions regarding the above information and possible consequences and risks. By signing below, I now agree to have the chiropractic care procedures recommended and performed. I have no questions, and I acknowledge no guarantee of cure had been made to me concerning results, care and treatment.

Patient name printed

Patient named signed

Eastside Chiropractic, PA

Consent for purposes of Treatment, Payment & Healthcare Operations (11/06)

In this document, “I” and “my” refer to the patient
And “Chiropractor” refers to Eastside Chiropractic, PA

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor. I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this consent.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right that Notice’s Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractor. The Notice of Privacy Practices for Chiropractor is also posted in the waiting room at 3014 Wade Hampton Blvd. Taylors, SC. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

**Signature of Patient
Or Personal Representative**

Printed Name of Patient

Date of Signing

**Description of Personal
Representative’s Authority**

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**ADVANCED WAIVER
Waiver of Liability and Patient's
Acceptance and Liability**

Your insurance plan, managed care program, or third party payor provides a limited range of benefits compared to the services available at this office. Your carrier provides coverage for "medically necessary" services as defined by them, for coverage or "eligible" benefits. In other words, no insurance carrier pays for everything. If possible, when the services you receive at this office exceed the covered or eligible benefit limits, or fall outside the payor's definition of "medically necessary" we will attempt to inform you in advance. Please understand that it is virtually impossible to predict in advance, given the literally hundreds of plans in existence today, what the insurance company will or will not pay. We will certainly comply with our contractual obligations when they exist, and apply the "appropriate" write-offs and fee reductions, but we make no representation that all services will be covered. As such you are responsible for anything not covered by the carrier that exceeds the benefits described in the insurance booklet provided by your employer or health carrier. We recommend you become familiar with your benefits so there are no surprises for either of us.

The following is a list of the services generally available at this office. Most insurances pay for spinal manipulation to some degree, but the benefits vary. The other services may or may not be covered. Again, check your insurance booklet for a listing of available benefits.

X-rays, exams, therapies, spinal manipulation, supplements, orthotics/ pillows/supports, ice packs, x-rays or x-ray interpretation, maintenance or supportive care, physical therapy modalities, rehab, educational classes, and many other services too numerous to list here.

There are numerous reasons for possible denial by your insurance company. Examples include: No referral from primary care provider, care deemed "not medically necessary", no prior authorization was obtained, treatment extends beyond initial allowance, etc. There are literally hundreds of reasons which your insurance company may give for denial of benefits. As always, we honor our contract with the carriers and apply the appropriate write-offs, but no insurance company pays for everything and you should become familiar with your benefit package.

PATIENT AGREEMENT AND ACCEPTANCE OF LIABILITY

As you know, our office participates with many third party payor programs and as a result it becomes virtually impossible to predict in advance you available benefits. By signing this agreement you acknowledge that *it remains your responsibility to understand your benefits*, and it remains our responsibility to *comply with any contract we have with certain carriers*. As such, we will apply the appropriate reductions and write-offs for "covered benefits" only. You must pay for all appropriate copays, deductibles, and non-covered benefits. Additionally, you agree that you have been notified that your carrier is likely to deny payment for the services identified above. If your carrier denies payment for any reason, you agree to be personally and fully responsible for payment.

Patient's Signature

Date

Please list the medications you are currently taking:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Please list the nutritional supplements you are currently taking:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____