INTEGRATED HEALTH
Exceeding your expectations

Consent to Treatment & Notice of Privacy Policy

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.

I, the signer, authorize the treating physician, intern, or staff (Dr. Logan Reading and/or associate doctors and/or other providers as such designated or whomever he may designate as his assistants, including staff or his intern), to perform chiropractic adjustments, treatments and procedures for which each is qualified and licensed to perform. I further consent to examinations, consulting services, and diagnostic procedures rendered in conjunction with the adjustments, treatments, and procedures for which each is qualified and licensed to perform. I understand that I have the right to refuse any procedure on an individual basis at any time simply by verbal notice regardless of giving permission now.

Release of Information

Integrated Health may disclose information from the my records to doctors, hospitals, or others for continuous care and to any third party (such as insurance companies) who requires that information in order to fulfill an obligation benefiting the patient. I acknowledge that I have been offered the HIPAA policy to read and take home and I am aware that this is a HIPAA compliant facility. No information will be released without my permission. Integrated Health may not disclose personal information for any other purpose. Integrated Health may disclose some basic information which is considered public knowledge such as my name on the signature sheet at the front desk and my name, occupation, and city in newsletters and similar media.

Responsibility for Payment

I acknowledge my responsibility to and agree to pay in full for the professional services rendered. I understand that if the doctor may bill my health insurer for the services if I have benefits coverage. I understand that such billing is a complimentary service and does not relieve me of my responsibility to pay for the treatment. I agree to pay for any costs incurred as a result of sending my bill to a collection agency or any other legal action. I, the undersigned, agree to pay all reasonable collection fees, legal fees, attorneys' fees, and court costs in the event legal action is taken to collect on the account. I, the undersigned, further agree to pay an additional amount representing fifty percent of the principal balance if the account is referred to a collection agency or attorney for collection. This additional amount is in recognition of the costs associated with said collection action processing.

Informed Consent of Risks

I understand that chiropractic care, massage therapy, and its supporting treatments and modalities, as with any health intervention, has inherent risks. These risks, though rare, could occur ranging from a minor aggravation of current condition to serious conditions such as cerebral vascular accidents. I also understand that the doctor is not liable for any problems that might arise if I decide not to follow the treatment which he or his staff prescribes. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks, including, but not limited to, sprain, strain, fractures, dislocations, and general aggravations of inflammatory conditions. I understand that I will have an opportunity to discuss with the doctor and/or intern and/or other office personnel the nature and purpose of the chiropractic procedures I will receive. I understand that the doctor and/or intern will perform an examination in order to minimize any risk of treatment; however, I do not expect the doctor and/or intern to be able to anticipate and explain all risks and complications. I therefore wish to rely on the doctor and/or intern to exercise judgment during the course of the procedure which the doctor and/or intern feels at the time, based upon the facts as then known, is in my best interest. I also understand that there may be risks in not getting treatment. I have the opportunity to discuss this with the doctor at any time. I understand some patients will feel some stiffness and soreness following the first few days of treatment and that this is common and almost always normal. I understand the doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if I have a condition that would otherwise not come to the doctor's attention, I understand it is my responsibility to inform the doctor. I understand fractures are rare

occurrences and generally result from some underlying weakness of the bone which is checked for during the history and during examination. I understand that if pathology is suspected, other exams will be recommended before treatment is rendered. I agree that by reading this that I am informed that stroke has been the subject of tremendous disagreement and that the incidences of stroke are very rare and are estimated to occur between one in two million and one in ten million cervical adjustments. I understand that other complications are also generally described as rare. Other treatment options 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
- Surgery
- Physical Therapy
- Possibly others

I understand if I choose one of the above noted "other treatment" options there are risks and benefits of such options and I may discuss these with the doctor or my primary medical physician.

I understand that remaining untreated may also have risks involved with it. Possible complications include having a serious, even life-threatening, condition go undiagnosed. It may also allow the formation of adhesions and reduce mobility which may set up a pain and inflammatory reaction further reducing mobility. Over time this process may lead to other health conditions and complicate treatment making it more difficult and less effective the longer it is postponed.

CVA Signs

If during or after your visit you suffer from any of the following **please notify the doctor or staff immediately**: Sudden severe pain in the side of your head and/or neck different from your current pain.

1. Vision problems
2. Changes in numbness, loss of feeling, or abnormal feeling
3. Changes in weakness, clumsiness, or loss of strength
4. Changes in dizziness
5. Changes in hearing problems
6. Disorientation or confusion
7. Speech problems
8. Loss of consciousness or momentary blackouts

I have read, or have had read to me, the above consent and reviewed the information in it and state that the same is true, correct and complete. I understand that the doctor is relying upon the information given by me in making a diagnosis and rendering treatment. I understand I will have the opportunity to discuss it with the doctor and have had my questions answered to my satisfaction before beginning treatment. By signing below, I agree to the procedures. I intend this consent form to cover the entire course of care for my present condition(s) and for any future condition(s) for which I seek care. I understand that I may have a copy of this consent and the HIPAA policy at any time.

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

Patient (or Guardian) Signature: _____ Date: _____