Joseph L. Erlandson D.C.
700 S. Main St.
Westby, WI 54667
Phone: (608) 634-3193 Fax: (608) 634-2193
westbywellness@gmail.com

INSURANCE ASSIGNMENT PROGRAM

1. Waiting for insurance payment is a courtesy provided by this clinic. We will bill your insurance company and accept assignment of benefits during your corrective care period.

2. This clinic does not promise that an insurance company will pay. The coverage that your insurance company quotes our clinic is not always accurate and we are not responsible for any information relayed to us incorrectly by your insurance company. In the event that the insurance company disputes or rejects a claim, it will be the patient's responsibility to pay all the charges not covered by the insurance company. In the event that and insurance company pays more than what was expected, you will receive a refund check.

Signature_____

Date_____

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INFORMED CONSENT OF CHIROPRACTIC TREATMENT

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a “click” or “pop”, such as the noise when a knuckle is “cracked” and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, and therapeutic ultrasounds traction may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury, or stroke could occur upon severe injury to arteries of the next. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or other minor-complications.

Probability of risks occuring: The risks of complications due to chiropractic treatment have been described as “rare”, about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury, or stroke, has been estimated at one in a million to one in ten million, and can be even further reduced by screening procedures. The probability od adverse reaction due to ancillary procedures is also considered “rare”.

Other treatment options that could be considered may include the following:

* Over-the-counter analgesics. The risks of these medications include irritation to stomach, liver, and kidneys, and other side effects in a significant number of cases.
* Medical care, 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 in conjunction with medical care adds the risk of adverse reaction to anesthesia as well as an extended convalescent period in a significant number of cases.

Risk of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition, and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me:

I have read the explanation above chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

X_____	X_____	X_____
Printed	Signature	Date

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USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION ACKNOWLEDGMENT & CONSENT

The federal laws that protect your protected health information (HIPPA) do not provide you with complete privacy. HIPPA allows your health care provider to use or disclose your protected health care information without further authorization to consent from you in a number of circumstances, such as:

* In the course to provide you treatment.
* In the event a referral to another health care provider if/as necessary for the diagnosis, assessment, or treatment of your health condition.
* For insurance and billing purposes.
* For internal clinic purposes (related to quality control or operations), and
* In limited and unusual circumstances related to public health matters and research.

Our privacy policy: We are very concerned with protecting your privacy, and always will respect the privacy of your health information. Along with this consent form, you will be given a copy of our privacy policy, in detail. You have the right to review our privacy policy before you sign this consent form. We reserve the right to change our privacy policy. If we make a change, we will notify you in writing when you come in for treatment or by mail.

Your right to limit uses or disclosures: You have the right to restrict out ability to use or disclose your protected health information with specific individuals, companies, or organizations. If you would like to place any restrictions on the use of disclosure of your health information, you must inform us in writing.

Your right to authorize us to disclose your protected health information: You have the right to authorize us to disclose your protected health information to specific individuals, companies, or organizations. If you would like to make and authorization, we will ask you to complete an authorization form.

Your right to revoke any limitation, authorization, or consent: You have the right to revoke any limitation or authorization to use or disclose your protected health information at any time. Your revocation must be in writing. If you refuse to give us an authorization or consent or revoke any authorization or consent in the future, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

I ACKNOWLEDGE receipt of the PRIVACY POLICY and CONSENT to my personal health information being used in the manner described above. I am also acknowledging that I have received a copy of this consent.

X_____ X_____
Patient Name Printed Date

X_____ _____
Patient Signature Authorized Patient Representative (Minor)

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APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organization to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at a time.

This notice is effective as of _____. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of authorization.

X_____ X_____
Patient Name Printed Date

X_____ _____
Patient Signature Authorized Patient Representative (Minor)