Hornbeck Chiropractic

Chad Hornbeck DC

Last Name _____ First Name_____

DOB _____

Address _____

_____

Home Phone_____

Cell Phone _____

Do You wish to receive text message reminders of your appointments? Y / N

Email Address _____

Primary Care Physician _____

1609 Woodbourne Rd
Levittown, Pennsylvania 19057
Tel :(215) 945-8090 Fax: (866) 326-6620

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Name:_____ **Date_____**

Please List any medications you are currently taking.

Please List Any Allergies to Medications

Please List Any Surgeries

Surgery	Date	Surgery	Date

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MEDICAL RECORDS AUTHORIZATION FORM

Regarding the Use & Disclosure of Health Information

I hereby authorize the following use or disclosure of my health information to:

Hornbeck Chiropractic & Rehabilitation

Entity or Person **To Whom** the Use / Disclosure Should Be Made:

_____

Description of Information to Be Used / Disclosed: ***Diagnostic Imaging and/or Lab Work***

Purpose of the Use / Disclosure: ***Clinical Correlation***

I understand that I may refuse to sign this authorization and that treatment and payment cannot be conditioned upon my completion of this form. I understand that this authorization may be revoked in writing except to the extent that your practice has acted in reliance thereon.

Name: _____

Signature: _____ Date: _____

If this authorization is being signed by a personal representative, describe the representative's authority to act for the individual:

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PATIENT CONSENT FORM

Regarding the Use & Disclosure of Protected Health Information

For the purposes of this Consent Form, "Office" shall refer to: Hornbeck Chiropractic and Rehabilitation
I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled, "Our Privacy Practices." I understand that I may review this privacy notice at any time prior signing this form.

I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this Consent in, but only to the extent that the Office has not taken action in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

Patient Name (please print): _____

Signature: _____ Date: ___/___/___

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ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below I acknowledge that I have received a copy of Hornbeck Chiropractic and Rehabilitation's Notice of Privacy Practices.

_____ _____

Signature of patient or personal representative Date

_____

If signed by personal representative, relationship to patient

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Office Use Only:

Our organization has made a good faith effort to obtain a written acknowledgement of receipt of the Notice provided to the individual named below.

Patient name: _____

Refused to sign ☐ Physically unable to sign ☐

(Other)_____

_____

_____

_____

Employee Signature:_____ Date:_____

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Informed Consent -- Chiropractic Care

Patient's Name: _____

General. I, the below-signed patient/individuals, have read this document and Care Plan in their entirety and understand the potential benefits and risks of the Care which you are recommending. I understand that there may be other forms of care which I may wish or need to seek provided by other health care practitioners. I also understand that there may be significant risks of not seeking any care for my condition.

Possible Risks of the Care; Alternatives

Chiropractic manipulation / adjustment. As with any healthcare procedure, I understand that there are certain complications, which may arise during chiropractic manipulation, and that those complications include: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. 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. I understand that fractures are rare occurrences and generally result from some underlying weakness of the bone. I also understand that stroke and other complications are also generally described as "rare."

Other Potential Alternatives. I understand that other treatment options for my condition may include: Self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; hospitalization with traction; and surgery.

Contraindications to Manipulation / Adjustment. I understand that you will not give me an adjustment / manipulation, x-rays, modalities, or therapies if you feel that such are contraindicated. In the event that the Care does not include such procedures, I have discussed all contraindications with you and fully understand them.

Definitions. "You" and "office" refer to any provider who renders care to me at the Location above. "Care" includes all care outlined in my Care Plan as well as any other care I receive from you in the future, including care related to other conditions.

Patient's Consent. I have thoroughly discussed and reviewed my recommended Care with you, as well as your examination, diagnoses, and thoughts regarding my condition, and also all of the information in this Informed Consent. I have had ample opportunity to explore other potential forms of care, have asked you all of the questions that I have, and have no additional questions. I voluntarily and knowingly elect to receive the recommended Care.

Patient's Name:

_____

Patient's Signature: _____Date of Signature: ___/___/___

Name of Parent / Guardian / Authorized Representative: _____

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