Maine Chiropractic Health Clinic, PA • Luc J. Dionne, D.C.

Patient Information

Last Name ______________________ M ___ First Name ______________________

Age ______ ☐ Male ☐ Female Referred by ______________________

Date of Birth _____/_____/_____ Social Security ______________________

Address ______________________

City ______________________ State __________ Zip Code ______________________

Home # ( ) ______________________ Work # ( ) ______________________ Ext. ______

Cell # ( ) ______________________ E-mail ______________________

Preferred Language: ______________ Race: ______________ Ethnicity: ______________

Employment Information

Employer ______________________

Occupation ______________________

Job Duties ______________________

Emergency Contact

Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Spouse's Name ______________________ Contact Number ______________________

Friend's Name ______________________ Contact Number ______________________

Insurance Information

Insurance Carrier ______________________ Insurance Plan ______________________

Policy Number ______________________ Group Number ______________________

Secondary Insurance ______________________

Primary Care Physician ______________________ Contact Number ______________________

Address ______________________

City ______________________ State __________ Zip Code ______________

I hereby authorize the insurance carrier listed above to make payment directly to the Healthcare provider and understand that I am financially responsible for all charges incurred and that are not covered in full by my insurance. I further understand that if I enroll in another insurance plan, it is my responsibility to notify the Healthcare Provider, otherwise I will be responsible for payment.

Patient Signature ______________________ Date ______________________

Informed Consent Form

Patient Name______________________________

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 unclear.

The Nature of the Chiropractic Treatment

The primary treatment used as a Doctor of Chiropractic is spinal manipulative therapy (SMT) or chiropractic adjustment. Throughout your treatment, I will mainly use this procedure to treat you. I also may use other adjunctive treatment or therapy as listed below. I may use my hand and/or mechanical or computerized instrument upon your body in such a way as to manipulate your joint. This usually causes the joint to cavitate, likely causing an audible sound associated with the procedure. You may feel a sense of movement in your joint which is usually painless.

Analysis/Examination/Treatment*

Spinal Manipulative Therapy
Neurological Evaluation
Range of Motion Evaluation
Muscle Strength Evaluation
Muscle Stimulation
Ultrasound
Palpation
Orthopedic Evaluation
Radiographic Evaluation
Gait Assessment with Scanning
Nerve Conduction Velocity Testing
Vital Sign Examination
Interferential Therapy
Organic Supplement
Other________________________

*Some of the above listed procedures might not be performed during first examination or subsequent visit and could vary from case to case.

The material risk inherent in Chiropractic adjustment

As with many healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fracture, disc injuries, dislocation, muscle strain, cervical myelopathy, costovertebral strain. Some techniques of neck manipulation have been associated with a higher risk of vascular injuries possibly leading to stroke. Some patients, an estimated 20% of the population, may feel stiffness and some soreness following the first few days of treatment.

I will make every reasonable effort to screen for contraindication to care and use a technique of manipulation which will be most suitable for you depending on your health history. However, if you have a condition that would otherwise not come to my attention which may impact your treatment (such as a recent accident), it is your responsibility to inform me.

The probability of those risks occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which shall be estimation during the taking of your history and/or during examination and/or X-Ray. In certain instances, I also will obtain results of your con densitometry, if I suspect potential risk with certain manipulative technique. Stroke has been the subject of tremendous disagreement. The incidence of stroke following Chiropractic adjustment or manipulation are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. In fact new studies suggest that stroke occurring in chiropractic offices are believed to be cervical dissection already in progress. The other complication mentioned above are also generally described as rare.

The availability and nature of other treatment options

Other treatment options for your condition may include:

Self-administered, over-the-counter (OTC) analgesics and rest
Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and painkillers
Hospitalization
Surgery
Epidural Injection

If you chose to use one of the above noted "other treatment" options, you should be aware that there are possible risks and benefits if you decide to opt for such options and you may want to discuss these with your Doctor of Chiropractic as to what should be your next step.

The risks and dangers attendant to remaining untreated

Please be aware that remaining untreated may allow the formation of adhesions and reduce mobility which may promote a pain reaction while further reducing mobility. Over time, this process may complicate treatment making it more difficult and less effective the longer it is postponed.

Do not sign until you have read and understand the above. Please check the appropriate block and sign below.

I have read ( ) or has been read to me ( ) the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Luc J. Dionne D.C. and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks and benefits involved in undergoing treatment and have decided that it is my best interest to undergo treatment recommended. Having been informed of the risks and benefits, I hereby give my consent to that treatment.

Patient

Dated______________________________

Patient's Name________________________

Signature____________________________

Signature of parent or guardian (if minor)

Doctor

Dated______________________________

Doctor's Name__Luc J. Dionne D.C.________

Signature____________________________

Luc J. Dionne D.C.

INSURANCE ASSIGNMENT

Our patients should understand and agree to the following:
1. You will be considered a cash patient until we qualify and accept your coverage.

2. You will be ultimately responsible for full payment of any and all services rendered.

3. Co-insurance and co-payment must be paid at the time of service, or once a week.

4. You must pay all deductibles in full.

5. If your insurance carrier has not paid a claim within 60 days of submission, you are responsible to take an active part in the recovery of your claim, and after 90 days you will be responsible for payment in full of any outstanding balance. 10% Interest will be added to your account after 90 days for delinquent payments.

6. If you are without any health insurance coverage you then qualify as a cash patient. Payment will be expected at time of service unless you have been approved for a payment plan by our billing department. Our office accepts check, cash, debit card, credit card and CareCredit as method of payment.

7. Our office reserves the right to use a collection agency for any unpaid balance, plus any fees incurred. **All fees** related to collection efforts will be added to the account. Collection fee of $25.00 will be added to account balance.

8. It is the patient's responsibility to make sure that we receive any required referrals from their Primary Care Physician for chiropractic services.

9. All durable orthopedic supplies are payable by the patient. Supplies such as Custom Fitted Orthotics, pillows, ice packs, gels or supplements are non-refundable. unless defective.

10. I hereby authorize payment of benefits directly to Luc J. Dionne, D.C. for services rendered. I further authorize Maine Chiropractic Health Clinic, PA./Luc J. Dionne to release any information required to process insurance claims.

I hereby acknowledge that I have read and understand this form.

Patient's Name : ________________________________ Date: _______________

Signature of Financially Responsible Party: _________________________________

120 Russell Street • Lewiston ME 04240 • ☎ 207-786-0393 • Fax: 207-795-0661

MAINE CHIROPRACTIC HEALTH CLINIC, PA

Luc J. Dionne, D.C.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: ______________________________ D.O.B.: ______________________

Address: ____

I hereby authorize _________________________________ to release my medical records to:

Maine Chiropractic Health Clinic, P.A./Luc J. Dionne, D.C.

120 Russell Street, Lewiston, Maine 04240

I understand that my medical record may contain sensitive information, including information regarding, AIDS, ARC, HIV, DRUG/SUBSTANCE ABUSE, SEXUALLY TRANSMITTED DISEASE, MENTAL ILLNESS, OR SEXUALLY ALLEGED SEXUAL ABUSE.

I have carefully read this form and I wish to have the designated medical information release. I understand that Maine Chiropractic Health Clinic, P.A. and those associated with his/her office have kept the information in my medical record in strict confidence, and expect that these records will be used only for the purpose for which they are requested and shall be held in a confidential manner to which I am entitled.

I will not hold Maine Chiropractic Health Clinic, P.A. responsible for any misuse of this information, which may occur. *A copy of this authorization shall be as valid as the original.*

______________________________ ______________________________

Signature (patient or guardian) Date

____

Witness

We respectfully request the following:

☐ Medical report(s) ☐ X-ray report(s) ☐ Blood test result(s)

☐ Hospital record(s) ☐ MRI report(s) ☐ Other: ________________

☐ Office note(s) ☐ X-ray film(s)

Luc J. Dionne, D.C.

ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, ____, have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.

Obtain payment from third-party payers.

Conduct normal health care operations such as quality assessments and accreditation.

____

Patient (print)

____

Signature Date

FOR OFFICE USE ONLY

We attempted to obtain written Acknowledgement of receipt of our Notice of Privacy Practices, but Acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the Acknowledgment
- ☐ An emergency situation prevented us from obtaining Acknowledgment
- ☐ Other (Please specify) ______________________________________

____

____

Staff signature Date

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