Dr. Michael J. Meath
2730 Carpenter Rd. Suite 3

Ann Arbor Chiropractic Wellness Center

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Print Name Date

_____

Signature of Patient or Personal Representative

_____

Description of Personal Representative's Authority

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Informed Consent

The doctor will use his hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as “Spinal Manipulation” or “Adjustment”. As the joints in your spine move, you may experience a “pop” as a normal part of the process.

There are certain complications that can occur as a result of a spinal manipulation. These complications include, but are not limited to, the following: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Homer’s Syndrome (also known as oculosympathethetic palsy), and costovertebral strains and separation. Rare complications include, but are not limited to, stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of the adjustment.

By signing this form, you are acknowledging that you are aware of these complications, and in order to minimize their occurrence the doctor will take precautions. These precautions include, but are not limited to, the doctor taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, please make the doctor aware of it.

_____ _____

Print Name Date

_____

Signature of Patient or Personal Representative

_____

Description of Personal Representative’s Authority