Healing Horizons

Integrated Health Solutions

## *Welcome to Healing Horizons Integrated Health Solutions*

## *CHIROPRACTIC CARE CONSENT*

Thank you for choosing Healing Horizons. We look forward to providing quality healthcare in order to assist you in achieving your health-related goals. In order to serve you as efficiently as possible, please answer all of the following questions and read and sign all forms. All information will be held in the strictest of confidence.

Name_____ Age_____ DOB_____ M F Marital Status_____ Phone_____
Address_____City/State_____Zip_____
Cell_____ If we may send you information, please provide your email_____
Occupation_____ Emergency Contact_____ Relation_____ Phone_____
Who referred you to Healing Horizons? _____ May we thank him/her? Y N

*****I voluntarily consent to be treated with chiropractic care by Joe Heinecke, DC, of Mountain Valley Chiropractic. Mountain Valley Chiropractic does not accept assignment for Medicare or insurance. This means that Mountain Valley Chiropractic does not see any Medicare enrolled persons. If you become Medicare enrolled while under the course of care by Mountain Valley Chiropractic, you will be referred to an appropriate Medicare provider. If you have insurance that contributes to your care, Mountain Valley Chiropractic will provide you with the appropriate documentation in the form of a "superbill" to help you with direct reimbursement from your insurance company. Mountain Valley Chiropractic cannot guarantee that your insurance company will reimburse you for services provided and assumes no role in recovering a reimbursement from your insurance company.
*I understand that chiropractic care involves hands-on touching of my body and can include sensitive areas including hips, sacrum, coccyx (tail bone), pubic bone, collar bones and ribs, lymph nodes in the armpits as well as palpation of muscles of both the upper and lower body. Some contact may need to be performed skin-to-skin, but most will be performed over my clothing. If at any time throughout the care I feel uncomfortable, or do not want contact made to a specific body part, I will let my practitioner know so that other arrangements for care may be made.
***Please initial*** _____
*I understand that some diagnostic or examination procedures may be performed if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable. Exams will be performed at the onset of care, annually or in the instance of an auto accident or serious injury.
*I understand that chiropractic care involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. Hands or an instrument are used to reposition anatomical structures. Potential benefits include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and well-being.
*I understand that no guarantees are given to me concerning the results and effects, and that I am free to stop or refuse treatment at any time. I also understand that there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. The best scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis. Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not.
*I understand that Dr. Heinecke does not diagnose or treat any condition other than the Vertebral Subluxation. However, while under the course of care, if he finds or suspects a different or more serious condition requiring treatment, he will inform you as well as recommend that you seek the services of a health care provider that specializes in that area of treatment.

*At times you may wish to contact Healing Horizons via email, or vice versa, for communication which may contain protected health information.
***Please initial for consent***_____

*I understand that the following providers will be present at Healing Horizons collaborative care meetings in which my care may be discussed: *April Schulte-Barclay*, DAOM, LAc; *Joseph Ellerin*, LAc, LMT, Dip. Hom, CST; *Cynthia Laprocina*, LAc, Dipl. Ac.; *Paula King*, PhD; *Raven Grinstead*, LMT; *Mariel Steel*, LMT; *April Ordaz*, LMT; *Joe Heinecke*, DC; *Michael Hawthorne*, DC; *Danielle Yahn*, RN. I also understand that other methods of collaboration, such as confidential email and private electronic group communication, may be used to coordinate my care in accordance with HIPAA regulations. ***Please initial for consent***_____
* ***I understand payment is due at the time of service and I agree to address any financial concerns with Healing Horizons prior to treatment. I understand that Healing Horizons gladly accepts cancellations up to24 hours in advance without penalty. The first late cancel or missed appointment is without penalty. Subsequent late cancel or missed appointments will be charged 100% of the scheduled treatment.***
***Please initial***_____

*The above named patient is a minor. As his/her parent/guardian, I give Dr. Heinecke permission to treat him/her without me being present at said treatment.
***Please sign for consent***_____***Date***_____

**I have carefully read and I understand all of the above information. I appreciate that it is not possible to consider every possible complication to care. I am fully aware of what I am signing.**

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Signature (Patient/Parent/Guardian) Date Rev1/22/2024