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 request and consent to be treated by Michael Hawthorne, DC, for the performance of chiropractic procedures, including various modes of physiotherapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible).

*I understand and I am informed that, as is with all healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

*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 Chiropractic adjustments and supportive treatments are designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure.

*I understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatory, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery.

*I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

*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. 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__________

***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 Rev 1/22/2024

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