CARUCCI CHIROPRACTIC CENTER, LLC
53 New Britain Avenue ~ Rocky Hill, CT 06067
PHONE 860-257-8445 ~ FAX 860-257-8084 ~EMAIL: Gina @ drcarucci.com

Family Health through Chiropractic

POLICY ON PERSONAL INJURY CASES

If you are treated for injuries caused by an automobile accident, the following **must** occur within one week of seeking care in order for your bill to be forwarded by us to the appropriate payor:

01: YOU MUST REPORT THE ACCIDENT TO YOUR OWN AUTO INSURANCE COMPANY AND OBTAIN A CLAIM NUMBER FOR US.

02: YOU MUST FILL OUT AN APPLICATION FOR BENEFITS BEFORE ANY TREATMENT IS RENDERED

03: YOU MUST HAVE YOUR ATTORNEY SEND US A LETTER OF PROTECTION IN THE EVENT THAT LEGAL REPRESENTATION IS NECESSARY.

04: YOU MUST PROVIDE US WITH A COPY OF YOUR PERSONAL INSURANCE CARDS AND YOUR DRIVER'S LICENSE.

05: YOU MUST PROVIDE THIS OFFICE WITH A COPY OF THE POLICE REPORT.

06: ALL REQUIRED PATIENT QUESTIONNAIRES ARE COMPLETED BY THE PATIENT.

07: YOU MUST PROVIDE US WITH ALL OF YOUR PRIVATE INSURANCE POLICY NUMBERS IN ORDER TO INSURE PROPER BILLING.

08: FAILURE TO KEEP REGULARLY SCHEDULED APPOINTMENTS MAY RESULT IN YOUR DISMISSAL FROM CARE IN THIS OFFICE AND REFERRAL TO ANOTHER PROVIDER.

09: FAILURE TO CALL TO CHANGE SCHEDULED APPOINTMENTS WITHOUT RESONABLE NOTICE WILL RESULT IN A CHARGE TO YOUR ACCOUNT FOR TIME RESERVATION.

If these items are not completed with in one week of first admission, pre-payment must be made prior to each subsequent visit and payment for care already rendered must be brought up to date.

DATE: _____

PATIENT NAME: _____

PATIENT SIGNATURE: _____

WITNESS: _____

DR. SIGNATURE: _____

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POLICY ON PERSONAL INJURY APPOINTMENTS

Because personal injury and worker's compensation cases involve not only medical issues, but also legal issues, it is important that you understand the following policies regarding care and treatment in this office. Furthermore, should Dr. Carucci or one of her Associates be asked to appear in court or at a deposition regarding your case, she will be asked under oath about the nature of your injuries and your adherence to the treatment plan.

Inconsistent treatment scheduling by you, along with missed appointments, may result in an insurance carrier or defense lawyer claiming that your injuries did not require treatment. It is our policy that if you miss three scheduled visits without a serious reason, you may be dismissed from care in this office and you will be asked to choose another doctor to manage your care. In addition, if you have an attorney, he or she must be informed about significant failure to attend scheduled treatments. There will be a charge for appointments which are not rescheduled within the same day if at least 24 hours notice is not given.

From a medical point of view, injured tissues do not heal well if inconsistent management occurs. Long term medical consequences may result causing unnecessary pain and suffering. We make every effort to schedule or re-schedule your visits so that obtain maximum medical benefit from each visit.

If you have any questions regarding your individual treatment protocol, please ask Dr. Carucci or your treating doctor of chiropractic at Carucci Chiropractic Center.

Patient Name: _____ Date:_____

Patient Signature: _____

Witness:_____

Dr. Signature: _____

Informed Consent

It is a standard of care to receive your informed consent prior to examination and treatment. The purpose of this form is to inform you, not alarm you. What you are being asked to sign is simply a confirmation that you have been informed of the following and have had the opportunity to ask questions and receive answers to your satisfaction by the doctor.

Examinations

X-rays, MRI's, Bone Scans and other diagnostic radiological procedures: This office does not perform any of these procedures, however if they are necessary, we will refer you to the most convenient facility.

Treatment

Chiropractic adjustment/manipulation: the doctor will use his/her hands or a mechanical device upon your body in such a way as to move your joints in various directions. This procedure may cause an audible "pop" or "click" to be hear coming from your joints, which is not cause for alarm. There are some risks involved in doing these procedures and they are as follows:

Pain: Chiropractic treatments may result in temporary increase in soreness in the area receiving treatment.

Rib Fracture: Fractures caused by chiropractic treatments are rare. They occur most frequently in patients with osteoporosis or weakened bones. Evidence of osteoporosis can be noted on your x-rays, and if detected, the most appropriate gentle treatments are used, minimizing the possibility of fractures to the ribs.

Disc Injury: Chiropractic treatment is appropriate for the treatment of many kinds of back problems, including some disc problems (1). Occasionally, chiropractic treatment may aggravate or cause a problem if the disc is in a severely weakened state. However, this occurs so rarely that statistics to quantify the probability are unavailable, but estimates place the risks of serious injury at about 1 serious complication per 100 million low back manipulations (2).

Stroke: The overall incidence of stroke in the general population is about 2.6 per 100,000. Although chiropractic adjustment/manipulation has been implicated as a possible cause of stroke, this possibility is extremely rare. The best available data suggests that stroke secondary to chiropractic adjustment/manipulation may occur in 1 per 400,000 - 5,800,000 (4) - a rate well below the overall average risk in the general population. In comparison, the overall average risk of death from taking non-steroidal anti-inflammatory drugs (aspirin, Ibuprofen, Naproxen Sodium, etc) is 4 per 10,000 patients (5). The risk of serious complication or death from spine surgeries of the neck is 11.25 per 1000 patients (5). As you can see, the risk of stroke from chiropractic treatments is much lower than other common medical treatments.

Chiropractic is a system of health care. As with any health care delivery system we

cannot promise a cure for any symptom, disease, or condition as a result of treatment in this office. We will always give you our best care, and if your results are not acceptable, we will refer you to another health care provider whom we feel will assist your situation.

If you have ANY questions about the above information, PLEASE ask your doctor to discuss them with you. When you have a full understanding, please sign and date the back of this form.

I have been informed of the most likely complications of the possible undesired results of chiropractic examination and treatment in this office and I understand them.

I hereby authorize Dr. Carucci and her associates or assistants to provide such additional services, as they may deem reasonable and necessary.

I hereby state that I have read or have had someone read to me this consent form.

Patient's Signature _____ Date:_____

Patient's Printed Name_____

Guardian's Signature_____Date:_____

Guardian's Printed Name_____

Witness' Signature_____ Date_____

Witness' Printed Name_____

References

1. Troyanovich SJ, Harrison DE. Low back pain and the lumbar intervertebral disc: Clinical considerations for the doctor of chiropractic. J Manipulative Physiol Ther 1999; 22(2): 96-104.
2. Shekelle PG, Spine Update: Spinal manipulation, Spine 1994; 19: 858-861.
3. Clayman CB. The American Medical Association Home Medical Encyclopedia. New York: Random House; 1989: 947-948.
4. Current Concepts in Spinal Manipulation and Cervical Arterial Incidents, An Executive Summary; NCMIC 2005
5. Dabbs V, Lauretti WJ. Risk Assessment of Cervical Manipulation vs NSAIDS for treatment of neck pain. J Manipulative Physiol Ther 1995; 18: 530-536.
6. Harwitz El, Aker PD, Adams AH, Meeker WC, Shekelle PG. Manipulation and mobilization of the cervical spine: A systematic review of the literature, Spine 1996; 21: 1746-1760.

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Authorizations

Carucci Chiropractic Center may need to use your name, address, phone number and your clinical records to contact you with appointment reminders/missed appointments, birthday cards, thank you's and newsletters or other health related information that may be of interest to you either directly, through the mail or through the internet. If this contact is made by the phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with regard to the above mentioned communications. In addition, we ask you to sign in at the front desk when you arrive. We occasionally ask your patients to fill out and sign a patient testimonial and we recognize children patients for our bulletin board. By signing this form you authorize us to allow your name to appear on the sign-in sheet, reception room testimonial book, thank you board, holiday card board, and for your child's picture to appear on the bulletin board.

Carucci Chiropractic Center may need to disclose your name, address, phone number, billing information and your clinical records to the Connecticut Chiropractic Association (CCA). This disclosure will be made if we need the CCA's assistance to receive reimbursement for your services or, we need the CCA's assistance because the party responsible for reimbursing your services has improperly processed your claim. By signing this form you are giving us authorization to send the CCA this information. You are also giving the CCA authorization to re-disclose your information to the party responsible for the payment of your services, the CCA's legal counsel, and state or federal agencies that may be asked to intercede on your behalf.

You may restrict the individuals or organizations to which you health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us, may be subject to re-disclosure by anyone has who access to the reminder, birthday, card, or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care. You may inspect or copy the information that we use to contact you to provide appointment reminders/missed appointments, birthday cards, thank you's and newsletters or other health related information at any time.

This notice is effective as of _____. This authorization will expire seven years after the date on which you last received services from this office.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

_____ _____
Patient name printed Date

_____ _____
Patient Signature Authorized provider representative

_____ _____
Personal Representative printed Personal Representative Signature

_____
Description of personal representative's authority to act for this patient.

Your right to complain

You may complain to us or to the Secretary for Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be addressed to:

Carucci Chiropractic Center
53 New Britain Avenue
Rocky Hill, CT 06067

U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

To contact us

If you would like further information about our privacy policies and practices please contact:

Office Manager
Carucci Chiropractic Center
53 New Britain Avenue
Rocky Hill, CT 06067
860-257-8445 Phone

This notice is effective as of _____. This notice will expire seven years after the date upon which the record was created. By signing below, I acknowledge that I have received a copy of this notice.

_____ _____
Patient name printed Date

_____ _____
Patient Signature Authorized Provider Representative

_____ _____
Personal representative printed Personal representative signature

_____
Description of personal representative's authority to act for the patient.