

# Roybal Chiropractic, P.S.

## Informed Consent

I, \_\_\_\_\_, patient, hereby request and consent to the performance of chiropractic spinal adjustments and other chiropractic procedures by Mario D. Roybal, B.S., D.C.

The following points have been explained to me, to my satisfaction, and I have had the opportunity to discuss them with the doctors of chiropractic.

1. Chiropractic care is the science, philosophy and art of locating and correcting spinal subluxation (misalignments) and as such, is oriented toward improvement of spinal function, relative range-of-motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptoms, disease of condition, as a result of treatment in this clinic.
2. I understand that the chiropractor will use his/her hands or a mechanical device upon my body to adjust a joint which may cause an audible "pop" or "click".
3. It is my intention to rely on the doctor to exercise professional judgment during the course of any procedures, which he/she feels at the time to be in my best interest.
4. Neither the practice of chiropractic or medicine is an exact science, but relies upon information related to the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgment and expertise in working with like cases.
5. It is not reasonable to expect the doctor to be able to anticipate, or explain, all possible risks and complications of a given procedure on any particular visit.
6. And undesirable result, or side effect, does not necessarily indicate an error in judgment or an improper treatment.
7. As with any health care professionals, there are certain complications which may arise during a chiropractic adjustment. Those complications include strain/sprains, dislocations, fractures, disc injuries, CVS's (cerebral-vascular accidents), or strokes. These complications are rare occurrences.
8. We acknowledge the new HIPAA laws and must have your permission to release any medical information.

In certain instances, additional information or precautions may be necessary for Chiropractic or Massage care. Please inform the doctor if you have any of the following conditions:

Active Cancer	Cardiac Problems	Use of Contacts
Severe Injuries	Chronic Illness	Recent Surgery
Arthritis	Phlebitis	Bursitis
High-Risk Pregnancies		

### **\*\*Massage Clients\*\***

A massage provides pain and tension relief by stretching and working the muscles. Please remove whatever clothing you feel comfortable removing or wear loose fitting clothing and lay face down under the cover. You are covered at all times with a sheet except for the area being worked on. There is relaxing music that you can choose from to listen to during your massage.

**\*\*A \$25 FEE WILL BE REQUIRED FOR MISSED MASSAGE THERAPY APPOINTMENTS IF WE ARE NOT NOTIFIED 24 HOURS IN ADVANCE OF THE CANCELLATION.**

After an adjustment or massage you may feel achy, experience a sore throat or other flu like symptoms. It is important to drink plenty of water before and after to help eliminate the above symptoms.

I have read the above consent, or had it read to me, have had the opportunity to ask questions and receive answers and I am comfortable with the information provided. I hereby request and consent to the performance of massage, chiropractic adjustments and other chiropractic procedures, including various modes of therapy and diagnostic x-rays, on me (or on \_\_\_\_\_, patient for whom I am legally responsible) by Dr Mario Roybal, B.S., D.C.; Dr Burk Thomas, D.C.; Brandy Schlegel LLC, LMP; Rachelle Jameson LMP; Wendy Marshall LMP.

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Print Parent/Legal Guardian Name

\_\_\_\_\_  
Signature of Patient or Parent/Guardian

\_\_\_\_\_  
Date signed

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date signed

### **HIPPA Privacy Practice Notice**

The undersigned acknowledges that they have had an opportunity to view and/or receive a copy of the Provider's Notice of Privacy Practice pursuant to HIPPA and consents to the use of their health information that is consistent with HIPPA and State and Federal Law.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **NOTICE OF RELEASE OF INFORMATION**

I, \_\_\_\_\_ AUTHORIZE Roybal Chiropractic to discuss and/or release my health care information to the following people. (Please include names of spouses, parents, power of attorney's, etc.)

NAME

RELATIONSHIP

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Roybal Chiropractic, PS

Mario D. Roybal, DC  
1203 W Francis Avenue, Spokane, WA 99205

## Notice of Non-Covered Services:

As your physician, I want to provide you with the best care possible. There are services that I feel are necessary for the treatment of your condition and maintenance of good health that may not be covered by your insurance health benefits contract. You are expected to pay for those services in full. Let me reassure you that I will order only the tests and treatments that I feel are necessary for your treatment and care. If you have any questions about whether or not a particular service is covered by your health benefits contract, you can call your insurance plan or someone in our office will be happy to assist you if it is something they can answer. Thank you for your understanding.

## Notice of Professional Fees:

Professional services at Roybal Chiropractic are consistent with the usual and customary healthcare practices, and actual services applied are specific to each case and health care needs. The services are described using standard universally accepted insurance language, and with fees set according to usual and customary rates. Because of the possibility that insurance may deny coverage for care rendered, or benefits may not fully cover services required in your care, we recommend that you look at our fees:

New Patient Exam/Evaluation & Management Services.....	\$84.50 - 240.00
Established Patient Exam/Evaluation Management Services....	\$20.00 - 165.00
Chiropractic adjustment/manipulations.....	\$25.00 - 53.00
Extraspinal/joint manipulations.....	\$20.00 - 30.00
Radiology professional interpretation....	\$15.00
MRI Professional review.....	\$50.00
Manual Therapy procedures...	\$20.00 - 45.00 per base time unit
Therapeutic exercise procedures.....	\$20.00 - 50.00 per base time unit
Neuromuscular reeducation procedures.....	\$40.00 - 55.00 per base time unit
Mechanical traction.....	\$35.00 per base time unit
Massage Therapy.....	\$50.00 - 66.00 per hour
Wellness.....	\$37.00 - 50.00 per unit

## Notice of Payment and Billing Policies:

Our office policy is that we DO NOT routinely send out billing statements or carry balances on your account. Payment is due at the time of service.

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I understand the disclosures and agree to the policies as set forth above.

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Signature

Printed name

Date