Heikkinen Chiropractic and Acupuncture Center
McDonald Chiropractic and Acupuncture Center
Authorization for Patient Communications

(Circle the correct answer)
May we contact you or send detailed messages related to your treatment/appointments by…….
Yes No Home Phone
Yes No Work Phone
Yes No Cell Phone
Yes No Mail
Yes No E-mail at Home E-mail Address_____
Yes No E-mail at Work E-mail Address_____
May we send postcard communications such as scheduling reminders, thank-you cards, sympathy cards, birthday cards, or holiday cards?
Yes No At Home
Yes No at Work
May we send you a periodic newsletter?
Yes No E-mail
Yes No Mail
May we discuss your treatment and/or appointment times with a spouse, parent or friend?
(Please List names below)

_____
_____
_____
_____

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

Heikkinen Chiropractic and Acupuncture Center
McDonald Chiropractic and Acupuncture Center

Consent for Purposes of Treatment, Payment and Healthcare Operations

I, _____[Name of Individual] consent to **Heikkinen Chiropractic, PC's and/or McDonald Chiropractic and Acupuncture Center** (the practice's) use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document. For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have a right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has acted in reliance on this consent.

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____[patient's name] acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices **of Heikkinen Chiropractic, PC, and/or McDonald Chiropractic and Acupuncture Center** which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

IRREVOCABLE ASSIGNMENT AND CONVEYANCE OF LIEN INTEREST IN INSURANCE PROCEEDS, GRANT OF POWER OF ATTORNEY AND PAYMENT AGREEMENT

THIS IRREVOCABLE, NON-RESCINDABLE, ASSIGNMENT AND CONVEYANCE OF LIEN INTEREST IN INSURANCE PROCEEDS is entered this date by and between the undersigned Health Care Recipient, hereinafter called "Patient", and **Heikkinen Chiropractic, PC** ☐ and/or **McDonald Chiropractic and Acupuncture** ☐ 820 E. Cartwright Road, STE 133, Mesquite, TX 75149-6063, hereinafter called "Provider".

WHEREAS, Patient desires to receive health care services from Provider and requests that Provider provide such services, but defer payment on the part of Patient for such services until Patient secures his/her insurance settlement proceeds. In consideration of Provider's willingness to agree to such terms and in accordance with the provisions of Tex. Ins. Code, Title 8, Subtitle A, Chapter 1204, §1204.053(a) [entitled "Assignment of Benefits"], Patient does hereby: (i) waive any obligation on the part of the Provider under Tex. Civ. Pract. & Rem. Code Ann., §146.002(b), and (ii) irrevocably assign and convey the following irrevocable lien interest, rights and benefits to Provider as the legal consideration and inducement to cause Provider to forego its legal right to require payment upon provision of services and wait for the payment of such benefits from Patient or Patient's representative. It is hereby agreed:

SECTION 1. Patient hereby irrevocably acknowledges full financial responsibility for all services provided to patient by Provider as consideration for such Provider services. Patient irrevocably assigns and conveys all causes of action, as permitted by Texas law, to which Patient has or may maintain an entitlement as a result of the automobile accident giving rise to Patient's insurance claim, as well as a lien interest to Provider in all benefits to which Patient has, may have, or may maintain a legal entitlement to receive in the form of future monetary proceeds due to be paid by or from any liability or health insurance plan(s), including PIP statutory insurance benefits, that are maintained by Patient or under which Patient derives some legal entitlement, as consideration for all health care services provided by Provider to Patent, up to the total amount of all unpaid charges for such Provider services. Patient irrevocably conveys and assigns to Provider such lien interest lien on any proceeds he/she is entitled to receive from any insurer, including his/her PIP insurance benefits up to the dollar amount of any unpaid charges owed by Patient to Provider. Such conveyance of lien interest shall be deemed hereunder to apply to: (i) any and all benefits, claims and/or monetary proceeds to which Patient may be or become entitled to receive, payable by or from any automobile medical or PIP insurance coverage maintained by Patient or any person under whose policy of insurance Patient may have a lawful right of recovery, (ii) any and all benefits, claims and/or monetary proceeds to which Patient may be or become entitled to receive, payable by or under any third party liability insurance coverage as a result of any claim for damages to which Patient may have a right of recovery, and (iii) a "common law lien interest" in, and all contractual rights and claims to, any and all insurance proceeds to which Patient has or maintains a legal entitlement, to be paid by or from any insurance company, health care benefit plan, or any other party contractually liable for payment of all or any portion of the charges for health care services rendered by Provider to the Patient as a result of the injuries sustained by Patient. This irrevocable conveyance and assignment of lien interest and conveyance and assignment of contractual rights to and for those charges attributable to Provider's health care services shall extend to, but not be limited to, Provider's entitlement to any and all claims to insurance proceeds payable as a result of any insurance coverage for damages borne by the Patient which has given rise to the above referenced health care services provider by Provider.

This irrevocable assignment and conveyance of cause of action and lien interest shall extend to the total amount of charges incurred by Patient for those services rendered by Provider. Patient agrees that full payment for all services rendered by Provider is due upon receipt of said services and Patient accepts full financial responsibility for payment for such services. Patient acknowledges that Patient is ultimately financially responsible for the payment of all services that Patient receives from Provider regardless of whether any portion of those fees and charges due to be paid by Patient to Provider are paid through insurance proceeds to which Patient has asserted a claim. Patient acknowledges that Provider's acceptance of Patient's irrevocable assignment of benefits and lien interest is a convenience to Patient, and that Provider may revoke this assignment and lien interest at any time.

SECTION 2. Patient hereby grants and conveys Provider Patient's causes of action, as permitted by Texas law, and this irrevocable lien interest against any and all monetary proceeds to which Patient may or have a legal claim against the party or parties that gave rise to Patient's claims for damages for which Provider has been engaged to provide healthcare services and any entitlement to insurance and/or health care payment proceeds due to be paid to Patient as a result of any claim Patient has or may have against any party whose negligence may have caused Patient's injuries or illnesses for which Patient has asserted Patient's pending insurance claim. Patient hereby grants this irrevocable lien interest against all such insurance or health care proceeds to which Patient is, or may become, entitled, including, but not limited to, all proceeds due to be paid on Patient's behalf out of any Medical Payment or statutory Personal Injury Protection insurance coverage, as a result of those services rendered to Patient by Provider. Said lien interests shall not exceed the total amount of expenses and debt obligations incurred, and due to be paid, by Patient to Provider for such services rendered.

SECTION 3. Patient hereby irrevocably directs all insurers, health care plans, legal counsel, and other persons or parties responsible for the payment, co-payment or other obligation for Patient's health care costs arising from injuries sustained by Patient for which the above referenced services have been provided by Provider, to remit and/or make all monetary payments remitted as consideration, in whole or in part, for those health care services rendered by Provider for and on behalf of Patient, directly to Provider. Patient further directs that any lawyer or representative employed by Patient to represent Patient in any action for which the above referenced services have been rendered by Provider, insurer or third party, shall be, and is hereby, irrevocably instructed and required to withhold from any monetary distribution to Patient, Patient's lawyer and/or any other person or party asserting any monetary interest against any proceeds to which Patient may awarded, the full amount of Patient's outstanding and unpaid account due and owing to Provider out of any private party settlement proceeds, insurance settlement proceeds of whatever nature (liability, PIP, etc.), and /or any court verdict and remit payment of the dollar amount of Patient's unpaid and outstanding account with Provider, directly to Provider immediately upon receipt of same. This directive made by the Patient to the Patient's lawyer is to be deemed irrevocable and non-rescindable and shall extend to and include any PIP or medical payment benefits recovered by or on the Patient's behalf of the Patient or Patient's lawyer.

SECTION 4. Patient willfully and voluntarily makes and appoints Provider, through its duly appointed representative of the City of Spring, Harris County, Texas, as Patient's lawful Attorney-in-Fact for purposes of receiving and directing disbursement of those payments of insurance or settlement proceeds to be paid to Patient, or on Patient's behalf, as compensation for those for the health care services rendered by Provider, and the resultant payment obligations owed by Patient to Provider as a result of same. Patient hereby delegates and conveys to Provider those rights and powers of substitution on Patient's behalf, to ask, demand, sue for, collect, endorse, sign, and receive such monetary proceeds, in Patient's name, to PIP insurance, other health benefits, and third party claims relating to services rendered to Patient by Provider. Although Provider is granted such special powers contained herein, Provider is not obligated or compelled to exercise such powers but may do so at Provider's discretion. Patient agrees

to cooperate with Provider to request and receive from any insurer, employer, or other third party payor any and all information or supporting documentation concerning or touching upon the handling, calculation, processing, or payment of any claims arising from services rendered to Patient by Provider.

SECTION 5. To the extent that Patient has lawful authority, Patient waives any applicable statute of limitations that may at any time interfere with Provider's right to collect for services rendered to Patient. Patient agrees that in the event Patient or Patient's authorized representative, including legal counsel, receives any check, draft, or other payment subject to this Agreement, Patient and Patient's authorized representative shall be deemed to serve in a fiduciary capacity to Provider, for the benefit of Provider, with full obligation to immediately deliver said check(s), draft(s), or payment(s) to Provider. Provider agrees to apply the proceeds from said check(s), draft(s), or payment(s) to Patient's debt for services rendered.

SECTION 6. Patient hereby irrevocable consents to, and authorizes, his lawyer/legal counsel to release to Provider, upon request by Provider, any and all records or documentation pertaining to Provider's insurance claims, legal claims, pending causes of action, or otherwise pertaining to the expense or charge for any service rendered by Provider for Patient's benefit.

SECTION 7. Patient irrevocably agrees and consents to Provider's submission of a copy of this Agreement and any other claim for payment of insurance proceeds to any and all insurance carrier(s) against whom Patient is, or may, assert or maintain any claim for damages and reimbursement for the cost for those services provided by Provider, including, but not limited to, any insurance coverage for Medical Payments, Personal Injury Protection or third party liability insurance payments. A copy of this document shall be as binding as the document bearing original signatures.

SECTION 8. In the event that any Section or provision of this Agreement is determined to be legally void, invalid, or unenforceable, all other Sections and provisions of this Agreement shall remain in full force and effect. Patient may not revoke the assignments and agreements contained in this document without the express written consent of Provider.

IN WITNESS WHEREOF, this agreement has been entered into the day and year set forth below.

☐ **Heikkinen Chiropractic, PC**
☐ **McDonald Chiropractic and Acupuncture**

_____

For the Clinic

_____ _____

Date **Patient Signature**

_____

Printed Name of Patient

_____ _____

Date **Parent Signature if Patient is a Minor**

_____ _____

Date **Witness**

Heikkinen Chiropractic and Acupuncture Center

McDonald Chiropractic and Acupuncture

Informed Consent Document

Patient Name_____DOB:_____Date:_____

All physical medicine procedures and treatment have some inherent risks. Our office takes every precaution to make sure that your treatment experience is safe and effective. This is a list of procedures that are routinely performed in our office:

spinal manipulation/adjustments	manual palpation	vital signs
range of motion testing	orthopedic testing	neurological testing
muscle strength testing	postural analysis	general physical exam
surface EMG	hot/cold therapy	electrical stimulation
radiographic studies	vertebral axial traction	nutritional supplementation
micro-current stimulation	therapeutic ultrasound	needle acupuncture
laser therapy	moxibustion	exercise prescriptions
intersegmental traction	other_____	

Chiropractic Treatment

The primary treatment used by doctors of chiropractic is spinal manipulative therapy, also called spinal adjustments. We use our hands or a mechanical instrument in such a way to induce movement in the joints. That may cause an audible "pop" or "click" similar to popping your knuckles. Sometimes, a sense of movement is felt.

As with any healthcare procedure, there are inherent risks with chiropractic treatment. Since we do not utilize drugs, or surgery, chiropractic treatment is much safer than any other form of primary healthcare. Most commonly, some people will feel stiffness and soreness following the first few days of treatment. This is completely normal. Rare serious complications include, but are not limited to: bruising, muscle strains, sprains, rib strains and rib separations, fractures, disc injuries, dislocations, nerve injuries, and burns from some types of therapies. Some types of manipulation of the neck have been associated with injuries to arteries in the neck leading to or contributing to serious vascular complications including stroke.

The probability of those risks occurring. Fractures are rare occurrences and generally result from some underlying weakness of the bone which our doctors check for during the taking of your history, during examination and x-ray. The association of stroke and manipulation has been the subject of much debate within the health care community. **The likelihood that a chiropractor will be made aware of an arterial dissection (stroke) following cervical manipulation is approximately 1 per 8.06 million office visits, 1 per 5.85 million cervical manipulations, 1 per 1430 chiropractic practice years and 1 per 48 chiropractic practice careers.** [(1)] The other complications mentioned are also generally described as extremely rare.

Acupuncture Treatment

Acupuncture traditionally involves the insertion of extremely thin needles through your skin at strategic points on your body called acupuncture meridian points. Acupuncture is most commonly used to treat pain. In addition to needles, other methods are used including electrical stimulation, laser, application of magnets or small pellets, heat and acupressure.

The possible complications from needle acupuncture include, but are not limited to: bruising and bleeding, infection, damage to nerves, or organs, pneumothorax, and needle fragments left in the body. Using heat modalities to stimulate acupuncture points can cause burns. Using needle-free topical micro-current stimulation greatly reduces the likelihood of any complications. Sometimes patients will feel a slight tingling or shocking sensation with micro-current, which is completely normal. To insure minimizing risks during acupuncture treatment, we take great care in needle placement, knowledge of general anatomy, and strict adherence to clean needle technique, so the likelihood of complications is extremely low.

In Summary

Our office will make every reasonable effort during the examination to screen for potential contraindications to care; however, if you have a condition that would otherwise not come to our attention through our examination and history, it is your responsibility to inform our doctors. Please notify us of any current or past health conditions, previous cardiovascular events, strokes, transient ischemic attacks, drop attacks, the use of any medications, especially the use of blood thinners. Our efforts to provide safe and effective treatment begin with your compliance to completely report your medical history.

Treatment Options

Other treatment options for your condition may include: self-administered, over-the-counter analgesics and rest; medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers; hospitalization; surgery. If you choose to use one or more of the "other treatment" options, you should be aware that there are risks and benefits with these options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated. Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW. I have read [ ] or have read to me [ ] the above explanation of the Chiropractic, Acupuncture and related procedures. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient Name: _____Date: _____ Doctor Initial _____Date: _____

Signature of parent or guardian (if a minor) _____Date: _____

(1) Sudden Neck Movement and Cervical Artery Dissection: The Chiropractic Experience CMAJ 2001; 165 (7): 905–906