Chiropractor General Patient Consent

Consent to Treat

I hereby voluntarily consent to all healthcare services ordered/provided by Ade Medical Group providers (Thomas Ade MD, and/or his Nurse Practitioners/Physician Assistants). For the remainder of the document the providers will be referred to as "Ade Medical Group". The health care service may include, without limitation, routine physical and mental assessment; diagnostic and monitoring tests and procedures; examinations and medical and/or dental treatment; routine laboratory procedures and test; x-rays and other imaging studies; administration of medications; and procedures and treatments prescribed by the center's healthcare providers. The health care services also may include counseling necessary to receive appropriate services including family planning (as defined by federal laws and regulations). I consent to examinations, treatments, procedures, and blood test ordered by the healthcare provider, which may include blood tests for diseases such as hepatitis and HIV AIDS. I understand that I will be asked to sign a separate informed consent for each vaccine to be administered and that I will receive a "Vaccine Information Statement" (VIS) prior to the administration of each vaccine. I understand that there is a separate consent form that I may be asked to sign for testing for infections conditions. I understand that there are certain hazards and risks connected with all forms of treatment, and my consent is given knowing this. I understand that this consent is valid and will remain in effect until I withdraw my consent, which may be done in writing at any time or until the center changes its services and asks me to complete a new consent form.

I understand that if this consent is signed on behalf of a minor, I may be required to sign a separate paternal consent form for the minor to receive family planning services. I understand that if this consent is being signed on behalf of a minor, this consent is valid until the minor turns 18, at which time the minor must consent for services on his/her own behalf.

Consent Collect Payment

I clearly understand and agree that all services provided to me are charged directly to me and that I am personally responsible for payment.

I acknowledge my responsibility to pay for that care according to the fees established.

If the patient is a minor, I am the parent and/ or guardian of said patient and I agree that I am responsible for all services provided to the patient herein.

The undersigned, responsible party agrees to be personally responsible for all changes. If, at any time or for any reason, the undersigned is unable to pay for services when due, the undersigned agrees to pay and authorizes Ade Medical Group to bill their account finance charges as described above. In the event it becomes necessary for Ade Medical Group to incur collection costs or institute suit to collect any amount due under this agreement the undersigned also agrees to pay collection fees and expenses, including reasonable attorneys' fees and court costs, plus all legal fees if incurred for collection, and submits to jurisdiction and venue in Rock Island County, IL.

HIPAA Acknowledgment of Privacy Practices

I have received a copy of the "Notice of Client Privacy Rights." This Notice details the various rights granted to me, the patient, under the Health Insurance Portability and Accountability Act.

Consent to View Prescription History and Electronic Prescription

I give permission for my medical provider to view all prescriptions filled at other pharmacies using my current prescription insurance plan. This includes checking prescription history with the prescription monitoring program for Illinois and surrounding states. If you reside in multiple states, all states will be checked in the database. I also understand that Ade Medical Group utilizes electronic transmission of my prescriptions through the EMR vendor of their choice.

Consent for Alternate person to bring Minor Child to Appointment

I understand that I, Parent/ guardian, must bring my child to the first appointment with an Ade Medical Group provider, to give a complete medical history. Following the first visit, I give permission for the following individual(s) to bring my child to Ade Medical Group for treatment. I understand that by giving permission for this individual(s) to bring my child to their appointment the individual(s) is fully authorized to consent to treatment prescribed by the Ade Medical Group provider.

Alternate individuals that may bring child to Ade Medical Group for treatment:

Name and Relationship: _____

Consent to release Information

May we release test results or appointment information to anyone other than you, (i.e., spouse, child)? Yes or No

If **YES,** please list first and last name, relationship to you and phone number:

NAME	**RELATIONSHIP**	**PHONE NUMBER**

Cell Phone, Text, and Message Policy

We provide courtesy appointment reminders via call/text and possibly other important information that may be placed using a prerecorded message. Initials Initialing here allows us to do that. Please fill the following consent out for additional services for each of your contact numbers:

Cell: ( ) - Can we leave a detailed message with test results, referral information, appointment times, etc? Yes No

Home:( ) - Can we leave a detailed message with test results, referral information, appointment times, etc? Yes No

Work: ( ) - Can we leave a detailed message with test results, referral information, appointment times, etc? Yes No

Circle your preferred number that we have your permission to leave a confidential voicemail (e.g. lab or test result, prescriptions, appointment information) **Cell** **Home** **Work**

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1. I certify that I have read and fully understand the foregoing consent and that the facts indicated above are true.
2. I realize that although every effort will be made to keep all risks and side effects to a minimum, risks, side effects, and complications can be unpredictable both in nature and severity.
3. I understand that Resident Physicians, Student Nurse Practitioners, and/or Student Physician Assistants may be involved in treatment, and I consent thereto.
4. I understand that mid-level providers (Physicians Assistants and Advanced Practice Registered Nurses) may be involved in treatment, and I consent thereto.
5. I understand that I may be asked to sign a separate informed consent form for certain treatment(s) that require such.
6. I hereby voluntarily give my consent to treatment at Ade Medical Group.
7. I agree with and will adhere to all above policies that are in this form.

I have read and agree to adhere to Ade Medical Group's General Consent

Printed Name of Patient/Guardian or Power of Attorney

Date

Signature of Patient/Guardian or Power of Attorney

Signature of Ade Medical Group Witness

Chiropractor Patient and Center Rights and Responsibilities

Welcome to Ade Medical Group. Our goal is to provide quality health care to qualified people in this community, regardless of their ability to pay. If we are enrolling new patients, you may be eligible to become our patient. As a patient, you have rights and responsibilities. We have rights and responsibilities also. We want you to understand these rights and responsibilities so you can help us provide better health care for you. Please read this statement and ask us any questions that you might have.

Human Rights:

1. You have the right to be treated with respect and dignity regardless of race, religion, sex, national origin, sexual orientation, gender identity, political affiliation, or ability to pay for services.

Payment for Services:

2. You are required to complete the registration process to determine if you are eligible for discounted fees for services. You are required to give us accurate information about your present financial status and any changes in your financial status as they occur. We need this information to decide how much to charge you.
3. You have the right to receive explanations of your bill. You must pay, or arrange to pay, all agreed fees for medical or dental services, as provided by our policies.
4. Federal law prohibits us from denying your primary health care services, which are medically necessary, solely because you cannot pay for these services. However, you are responsible for your fees and need to act in good faith to plan for payment of the services received.
5. The undersigned, responsible party agrees to be personally responsible for all changes. If, at any time or for any reason, the undersigned is unable to pay for services when due, the undersigned agrees to pay and authorizes Ade Medical Group to bill their account finance charges as described above. In the event it becomes necessary for Ade Medical Group to incur collection costs or institute suit to collect any amount due under this agreement the undersigned also agrees to pay collection fees and expenses, including reasonable attorneys' fees and court costs, plus all legal fees if incurred for collection, and submits to jurisdiction and venue in Rock Island County, IL

Privacy:

6. You have the right to have your interviews, examinations, and treatments in privacy. Your medical records are also private. Only legally authorized persons may see your records unless you request in writing for us to show them to someone else. A complete discussion of your privacy rights is attached in the "Notice of Client Privacy Rights." By signing this document, you are indicating that you have received this Notice. The Notice details the various rights granted to you under the Health Insurance Portability and Accountability Act.

Health Care:

7. You are responsible for providing us with complete and current information about your health or illness, so we can provide you with proper health care. You have the right to and are encouraged to participate in decisions about your treatment.
8. You have the right to information and explanations in the language you normally speak and in words that you understand. You have the right to information about your health or illness, treatment plan (including risks) and expected outcome, if known. If you do not wish to receive this information, or if it is not medically advisable to share that information with you, we will provide it to a legally authorized person.
9. You have the right to information about Advance Directives. Please let us know if you need assistance in getting Advanced Directives in place.
10. You are responsible for appropriate use of our services, which includes following our staff's instructions, making, and keeping scheduled appointments, and only requesting a "walk in" appointment when you are ill. We may not be able to see you unless you have an appointment. If you do not understand or cannot follow the staff's instructions, please tell us so we can help you.

11. If you are an adult, you have the right to refuse treatment to the extent permitted by law, and to be informed of the risks of refusing such care. You are responsible for the outcome of refusing treatment.
12. You have the right to healthcare and treatment that is reasonable for your condition and within our capability. You have the right to be transferred or referred to another facility for services that we cannot provide. However, Ade Medical Group is not required to pay for services that you get elsewhere. Note: Ade Medical Group is not an emergency facility.
13. If you are in pain, you have the right to receive appropriate assessment and management, as necessary.

AccessHealth Rules:

14. As with any organization, Ade Medical Group has rules for the use of our services. Patients are responsible for understanding the rules and using our services in an appropriate manner. Ade Medical Group property or services may not be abused, and it is an expectation that all patients treat our employees and facilities with respect. If you have any questions, please ask.
15. Parents are responsible for the supervision of children brought with them to Ade Medical Group. You are responsible for their safety and the protection of other clients, and our property. Please do not leave your children unattended.
16. You have a responsibility to keep your scheduled appointments. Missed scheduled appointments cause a delay in treating other patients. If you do not keep scheduled appointments or if you cancel your appointment with less than 24-hour notice, you may be charged a late fee of $50.00 (not billable to insurance, this is the patient's responsibility).

Complaints:

17. If you are not satisfied with our services, please tell us. We want suggestions so we can improve our services. We will tell you how to file a complaint. Completed Client Suggestion/Complaint forms shall be reviewed by the appropriate supervisor. You shall receive a response from Ade Medical Group by mail or phone regarding the outcome of your complaint or suggestions. If you are not satisfied with how we handle your complaint, you may file a complaint with the Practice Manager at Ade Medical Group.
18. At no time will your complaint affect the care you are entitled to receive.

Termination:

19. Ade Medical Group can decide to stop treating you as a patient. If we stop treating you as a patient, you have the right to advance notice that explains the reason for the decision and will be given 30 days to attempt to find other health services. After notice of termination, we will only provide urgent care for a 30-day period while you find a new provider. We can decide to stop treating you immediately and without notice, if Ade Medical Group has determined that you have created a threat to the safety of the staff and/ or other clients. Other reasons for which we may stop seeing you include:
    a. Failure to obey Ade Medical Group rules,
    b. Intentional failure to report accurate information concerning your health,
    c. Intentional failure to follow the health care program, such as instructions about taking medications, personal health practices, or follow-up appointments, as recommended by your doctor,
    d. Creating a threat to the safety of the staff and/or other clients, and/or
    e. Intentional failure to accurately report your financial status.

Chiropractor Appointment and No-Show Policy

Ade Medical Group is committed to providing prompt medical care to all our patients. We understand that situations arise in which patients must cancel their appointments. It is therefore requested that patients who must cancel their appointments provide at minimum a 24-hour notice. This will enable another patient who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made in less than 24 hours, we are unable to offer that appointment slot to other patients who wish to be seen. Patients who do not show up or call to cancel their appointment will be considered a **NO SHOW**.

A **NO SHOW** is when a patient fails to keep a scheduled appointment or is more than 15 minutes late. Patients are advised to arrive 15-30 minutes prior to their scheduled appointment to allow time for parking, check-in and required paperwork.

If the patient is delayed and cannot make an appointment on time, the patient must call to advise us of the situation and provide an estimated time of arrival. Any significant delay may require the patient to wait for the next available appointment, which may be with a different provider. If none becomes available, the patient will be rescheduled.

If a patient has a special circumstance regarding a missed appointment, the patient may contact the clinic to discuss the special circumstance. We understand that there may be issues beyond the patient's control and want to be understanding of special circumstances.

Patients who "no show" 3 times or more within a 12-month period may be terminated by the provider.

When making an appointment, adult patients must choose between a well visit or a sick visit since both cannot be accommodated on the same day since the patients' insurance often may not pay for both. Only pediatric patients can have both types of visits on the same day.

Due to the current nature of insurance-based medical practices, we ask that patients limit their medical problems to **1 TO 2 ISSUES only**. Should the patient have more medical issues that need to be addressed, the patient must inform our staff when calling for appointments. Our providers may request patients to return for follow-up visits to address additional medical concerns.

Multiple family member appointments **must be** scheduled in advance. Family members who are present at the time of another member's appointment, but are not scheduled, will be required to schedule an appointment later.

NO CALL NO SHOWS AND CANCELLED APOINTMENTS (WITH LESS THAN 24 HOURS NOTICE) MAY BE CHARGED A FEE OF $50.00 WHICH IS NOT BILLABLE TO YOUR INSURANCE AND WILL BE YOUR RESPOSIBILITY TO PAY.

I have read and agree to adhere to Ade Medical Group's:

Patient and Center Rights and Responsibilities
"Appointment and No-Show Policy."

Printed Name of Patient/Guardian or Power of Attorney	Date
Signature of Patient/Guardian or Power of Attorney	Signature of Ade Medical Group Witness