Houston Center for Pediatric Therapy

Personal Data

Child's Name:_____ DOB:_____ Age:_____ Sex:_____
Address:_____
Cell Phone: _____ Home Phone:_____
Child's Diagnosis (if any):_____
Child's Primary Care Physician:_____
Child's Referring Physician:_____

Family Information

Mother's Name:_____ DOB:_____
Education Completed through:_____ Occupation:_____
Employer:_____ City, State_____ Work Phone:_____
Father's Name:_____ DOB:_____
Education Completed through:_____ Occupation:_____
Employer:_____ City, State_____ Work Phone:_____
Stepmother/Stepfather Name (if applicable) Name:_____
Education Completed through:_____ Occupation:_____
Employer:_____ City, State_____ Work Phone:_____

Referral Information:

Who referred you to this facility?:_____
Please write a description of the child's problem as you see it. Please include any information which you may feel be helpful:_____

Houston Center for Pediatric Therapy

Pregnancy and Birth

Length of Pregnancy:_____ Baby's birth weight:___ lbs ___ oz___ length
Medications taken during pregnancy:_____
Describe:_____
Difficulties during pregnancy:_____
Difficulties during delivery:_____
Delivery Method (circle one): Vaginal Breech Forceps C-Section
Is the child adopted?:_____ If yes, at what age?_____

Pregnancy and Birth Continued

Difficulties following birth:

- Trouble Breathing _____
- Turned yellow _____
- Turned Blue _____
- Required Oxygen _____
- Required Incubation_____
- Trouble Sucking _____
- Incubation_____

Difficulties during infancy:

- Sucking_____
- Swallowing_____
- Sleeping_____
- Limp_____
- Rigid_____
- Irritable_____
- Overactive _____

Length if stay in hospital:_____
Please list any other difficulties following birth or during infancy:_____
_____

Developmental History

At what age did the following occur?

- Sat up without help_____
- Crawled _____
- Walked_____
- Spoke 1st word_____
- Put words together_____
- Fed self _____
- Bladder Control _____
- Bowel Control _____
- Dressed self_____
- Bed Wetting? Y / N

Was the child breastfed or bottle fed?_____ Any problems?_____
Does the child have any problems with feeding/oral motor (i.e.chewing, swallowing, drooling, exaggerated gag reflex)?_____ If yes, Please describe_____
_____

Houston Center for Pediatric Therapy

Were there periods when the child quit talking?_____ Describe:_____

_____

Does the child babble?:_____ At what age?_____

Age when child combined two words? (for example,want cookie?)_____

Age when child combined three words?(for example, go bye-bye?)_____

Approximate # of words in vocabulary?_____

Health and Medical History

Childhood Illnesses (check if yes, note frequency and age)

Ear Infections_____ Tubes in ears_____

Tonsillitis_____ High Fevers_____

Frequent Colds_____ Respiratory Infections_____

Allergies (please list all):_____

Seizures? If yes, when was the last one?_____

Please list and describe any other important injuries, illnesses and major operations and when they happened_____

Has the child ever been to a dentist? Tongue or lip tear ever reported?_____

Has the child been to a neurologist? If yes, when and what were the results?_____

_____

What other therapies is the child receiving?_____

Has vision been examined? If yes, when and what were the results?_____

Does the child wear glasses?_____ At what age were they prescribed?_____

Please list all medications child is currently taking and what they were prescribed for:

_____

_____

Behavior

How does he/she get along at home?_____

How does he/she get alone at daycare/school?_____

How does he/she get along with other children?_____

What is his/her attitude toward daycare/school?_____

Difficulty sitting still?_____

Difficulty paying attention?_____

Other behavioral problems?_____

Describe the child's strengths and/or special interests_____

Houston Center for Pediatric Therapy

Education

If your child is not in school yet, where does he/she stay during the day?_____

If your child is in school, please complete the following:

Name of school:_____ Grade/Level:_____

Type of class (i.e. regular, special education)_____

If special education, what label was used to qualify child?(ex: Learning disability)_____

Does your child receive therapy in school? If yes, who is his/her therapist?_____

_____

Handedness (complete either right or left with each activity):

Writing_____ Throwing a ball_____ Eating_____

Family History

Siblings: Name_____ DOB_____ Name_____ DOB_____

Name_____ DOB_____ Name_____ DOB_____

Other persons living in the same home and relationship to the child:_____

Language spoken in the home:_____

Has anyone in the family ever had speech, language, swallowing, hearing or learning problems? If yes, what was the problem and who was it?_____

_____

Personal Goals

If your child requires therapy, what are your personal goals? What things would you like your child to learn? Please list goals in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Houston Center for Pediatric Therapy

Tactile:

Does or did your child:

Have a strong need to touch objects or people?_____

Excessively dislike having hair or face washed?_____

Avoid certain textures of food?_____

Dislike the feeling of certain types of clothing? If so, please explain_____

Seems almost unaware of or "stoic" over painful experiences such as having shots, stitches, dental work? If so, please explain_____

Often unaware of bruises, cuts, bleeding gashes from playing until someone brought it to his/her attention?_____

Were sleep patterns in infancy and/or childhood irregular? Please explain_____

_____

Is it difficult to get your child to sleep, or comfort your child now?_____

Would you describe your child as a quiet or active baby?_____

Fine Motor

Does or did your child:

Manipulate small objects easily?_____

Have difficulty with paper and pencil activities? Please give example _____

_____

Have difficulty fastening and unfastening clothes? If so, what type of clothes_____

_____

Shift positions constantly while sitting or standing?_____

Have a weak grasp?_____

Have one side that seems stronger than the other? _____

What type of manipulative activities/toys does your child normally enjoy?_____

Play with toys that are age appropriate?_____

Likes puzzles and other manipulative toys?_____

Is (was) your child clumsy in playing with toys? Please explain_____

_____

Are/were manipulative hand skills difficult for your child? (i.e. use of spoon, cutting, etc.)

_____

_____

Houston Center for Pediatric Therapy

Social

Does your child play with siblings and/or children in neighborhood/school?_____

Briefly describe these interactions_____

_____

What are your child's favorite playtime toys and activities?_____

_____

Describe your child's play when involved in these activities?_____

_____

How would you describe your child's social skills? _____

_____

Parent/Guardian Signature:_____ Date:_____

Relationship to the Child:_____

Houston Center for Pediatric Therapy

Consent for Therapy Evaluation and Treatment:

I authorize the Center for Pediatric Therapy to provide appropriate evaluation and treatment as needed. I have reviewed the Practice Policies and understand them.

Patient Name: _____ Date: _____

Parent/Guardian Name: _____ Signature: _____

Behavior Policy:

Here at the Houston Center for Pediatric Therapy we make every effort to meet the needs of your child while receiving their OT/PT/ST services. However, we are not trained behavioral therapists and if your child negatively impacts the therapeutic environment such as safety for themselves or others, then services will be put on hold for you to seek guidance from a trained behaviorist. It's our belief that a child cannot receive the maximum benefit from OT/PT/ST until behaviors have been addressed. We are happy to work with you and help you navigate seeking the appropriate specialist. Once an appropriate behavior plan is in place, we encourage you to return so that your child can participate while fully engaged resulting in greater benefits and progress in therapy.

_____ (initial) I acknowledge I have read and understand the above.

Parent/Guardian Signature : _____ Date: _____

PATIENT ACKNOWLEDGEMENT OF BILLING PRACTICES

Spine & Rehab Associates, PLLC has multiple affiliations to care for patients and their healthcare needs.

A patient may be treated with the professionals and clinicians in one or more of the affiliates of Spine & Rehab Associates, PLLC. The treating doctors, physical therapists, clinicians and medical directors include, but are not limited to:

Brett Baer, PT, DPT
Beth Jones, OTR
Makayla Iordache, COTA
Giselle Trevino, COTA
Cynthia Nolan, OTA
Kelsey Elliott, OTR

Kandis Dennis,PT. DPT
Cecilia Lopez, PT, DPT
Savanna Smith, PT, DPT
Jason DeMattia, MD
Candice DeMattia, MD
Cathryn Darnell, PTA
Jared Seulean, PTA

Taylor Payne, PTA
Jennifer Anklam, PTA
Karina Montelongo, PTA
Erin Nava, MS, CCC, SLP
Katie Blood, MS, CCC, SLP
Hannah Hinch, MS, CCC, SLP
Shannon Grimm, SLP, CF

Due to the multiple disciplines utilized for patient care, Spine & Rehab Associates, PLLC is under the direction of our **Medical Directors, Dr. Alan Moore, MD, DABA, ABAPM, Dr. Candice DeMattia, MD, Dr. Jason DeMattia, MD, Dr. Brett Baer, PT, DPT**.

Due to the multiple disciplines utilized for patient care, Spine & Rehab Associates, PLLC is under the direction of our Director of Therapy, Dr. Brett Baer, PT, DPT.

- ✓ All claims for patient care are submitted to insurance companies **under the direction of our Medical Director(s) and/or Director of Therapy**.
- ✓ Our Medical Director(s) and/or Director of Therapy are in-network with most major medical insurance plans and **their names will appear on all explanations of benefits and correspondence from the insurance company**.
- ✓ During patient care, the **benefit levels that will be utilized on insurance plans are the specialist and therapy benefits**.

By signing this acknowledgment, the patient understands the billing practices of Spine & Rehab Associates, PLLC and its affiliates. If there are any questions, please contact our office.

PATIENT NAME _____ PARENT/GUARDIAN SIGNATURE _____ DATE _____

Houston Center for Pediatric Therapy

Patient Name _____

CREDIT CARD ON FILE AGREEMENT

Spine & Rehab Associates, PLLC / Houston Center for Pediatric Therapy offers a Credit Card on File program as a convenient method of paying charges not covered by insurance such as: copay, deductible, co-insurance, and no show/cancellation fees. Your credit card information will be kept confidential and secure.

I (we), understand, authorize and request that Spine & Rehab Associates, PLLC / Houston Center for Pediatric Therapy charge my credit card for any balance due identified as my financial responsibility including no show and cancellation fees. This authorization also relates to all charges not covered by my Insurance company for services provided to me by Spine & Rehab Associates, PLLC / Houston Center for Pediatric Therapy. My card will remain securely stored for future use. This authorization will remain in effect until revoked by me in writing.

Charge Limits: Balances exceeding $500 require verbal authorization from me. Charges under this amount require no further authorization.

_____ _____

Patient or Parent/Guardian Signature Date

Houston Center for Pediatric Therapy

Patient Name _____

APPOINTMENT CANCELLATION AND RESCHEDULING POLICY

We understand that situations arise in which you must cancel or reschedule your appointment. It is therefore requested that if you must cancel or reschedule your appointment, you provide more than 24 hours notice. This allows us to manage our appointments more efficiently and accommodate the needs of our patients.

APPOINTMENT CANCELLATION FEE

Please be advised that appointments not canceled or rescheduled at least 24 hours in advance will result in a charge of $25. This fee is to cover the time that was set aside specifically for you, as last minute cancellations impact not only our team but also other patients that could have been seen in your place.

Any patient with a recurring appointment time who no-shows or cancels less than 24 hours prior to appointment time twice within 60-days will lose the right to their scheduled appointment time.

Cancellation fees are the responsibility of the patient/guarantor, and are therefore not billed to the insurance. Fees are due at the time of cancellation.

HOW TO CANCEL OR RESCHEDULE YOUR APPOINTMENT

To Cancel or Reschedule Your Appointment, please call us directly at 281-292-4800 during our business hours. If you need to cancel or reschedule outside of our business hours, please leave a voicemail message or text us at 281-626-7188.

ACKNOWLEDGEMENT

By signing below, you acknowledge that you have read and understand this policy regarding appointment cancellations and rescheduling. You agree to be bound by its terms and conditions, including the imposition of a **$25 fee for any appointment not canceled or rescheduled at least 24 hours in advance and a $50 fee for no notification and/or not attending any scheduled appointment.**

_____ _____

Patient or Parent/Guardian Signature Date

TREATMENT COMPLIANCE POLICY

• The outcome of your treatment could be negatively affected by your inability or unwillingness to abide by and/or maintain the proposed course of treatment. Just as you expect our office to be considerate of your time, we ask for the same courtesy. If you are unable to make a scheduled appointment, please contact our office so that we may provide another patient with that time slot. Success with your treatment in our office is our primary concern and compliance with our treatment plan is essential.

• The undersigned patient hereby acknowledges that he/she is seeking care and treatment from Spine & Rehab Associates, PLLC and that the provider(s) will rely on the patient for giving truthful statements regarding the facts and circumstances surrounding his/her illness and/or injury. Any untruthful statements can possibly lead to the rendering of an improper diagnosis and/or unnecessary treatment.

I, the patient, therefore attest that the questions responded to above and throughout my paperwork are truthful and accurate.

_____ _____

Patient or Parent/Guardian Signature Date

POLÍTICA DE CUMPLIMIENTO DEL TRATAMIENTO

- El resultado de su tratamiento podría verse afectado negativamente por su incapacidad o falta de voluntad para acatar y/o mantener el curso de tratamiento propuesto. Así como usted espera que nuestra oficina sea considerada con su tiempo, le pedimos la misma cortesía. Si no puede asistir a una cita programada, póngase en contacto con nuestra oficina para que podamos ofrecer a otro paciente ese espacio de tiempo. El éxito de su tratamiento en nuestra oficina es nuestra principal preocupación y el cumplimiento de nuestro plan de tratamiento es esencial.

- El paciente abajo firmante por la presente reconoce que él/ella está buscando atención y tratamiento de Spine & Rehab Associates, PLLC y que el médico(s) se basará en el paciente para dar declaraciones veraces sobre los hechos y circunstancias que rodean su enfermedad y/o lesión. Cualquier declaración falsa puede conducir posiblemente a la prestación de un diagnóstico inadecuado y/o tratamiento innecesario.

Yo, el paciente, por lo tanto atestiguo que las preguntas respondidas arriba y a través de mi papeleo son veraces y exactas.

_____ _____

FIRMA DEL PACIENTE/TUTOR FECHA

AUTHORIZATION FOR CONTACT

I authorize the team of Spine & Rehab Associates, PLLC to contact me at my home, cell, or any other alternate phone number that I have listed.

I authorize Spine & Rehab Associates, PLLC to leave a voicemail or text message phone numbers on file in reference to any items that assist the practice in carrying out treatment, payments and healthcare operations (TBO), such as appointment reminders, insurance items, billing and any other calls or texts pertaining to my clinical care including lab results among others.

AUTHORIZATION FOR U.S. MAIL AND EMAIL

I authorize Spine & Rehab Associates, PLLC to mail to my home or email any items that assist the practice in carrying out TPO, such as appointment reminders, documentation to refer out for services, documentation requested by myself and patient statements. I understand that as with any internet service, there is a risk of sending information through email. All records are kept in our Electronic Medical Record.

_____ _____

Patient or Parent/Guardian Signature Date

AUTORIZACIÓN DE CONTACTO

Autorizo al equipo de Spine & Rehab Associates, PLLC a ponerse en contacto conmigo en mi casa, celular, o cualquier otro número de teléfono alternativo que he enumerado.

Autorizo a Spine & Rehab Associates, PLLC a dejar un correo de voz o mensajes de texto números de teléfono en el archivo en referencia a cualquier tema que ayudan a la práctica en la realización de tratamiento, los pagos y las operaciones de atención médica (TBO), tales como recordatorios de citas, artículos de seguros, facturación y cualquier otra llamada o textos relacionados con mi atención clínica, incluyendo los resultados de laboratorio, entre otros.

AUTORIZACIÓN PARA CORREO POSTAL DE EE.UU. Y CORREO ELECTRÓNICO

Autorizo a Spine & Rehab Associates, PLLC a enviar por correo a mi casa o correo electrónico cualquier artículo que ayuda a la práctica en la realización de TPO, tales como recordatorios de citas, documentación para referirse a cabo para los servicios, la documentación solicitada por mí mismo y las declaraciones de los pacientes. Entiendo que como con cualquier servicio de internet, hay un riesgo de enviar información a través de correo electrónico. Todos los registros se guardan en nuestra Historia Clínica Electrónica.

_____ _____

FIRMA DEL PACIENTE/TUTOR FECHA

NOTICE OF PRIVACY PRACTICES - PHI RELEASE

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be Involved in that treatment directly and indirectly
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I agree to receive an electronic copy of the Notice of Privacy Practices (available via the Patient Portal or by contacting the practice) containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request In writing that you restrict how my private Information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, that you are bound to abide by such restrictions.

By acknowledging below I give my consent for Spine & Rehab Associates, PLLC to use and disclose my protected health information (PH) in the ways described in the Notification and to carry out treatment, payment, and healthcare operations (TPO).

I have read or been given the opportunity to read the Notification of Privacy Practices and agree as indicated above.

Due to the privacy laws mentioned above, we are unable to discuss your PHI (Including appointment information) with any family member without your express consent. If you would like us to be able to discuss any aspect of your PHI with a spouse, parent or other family member please list them below. For minor children we will follow any applicable state or federal laws regarding release of information.

I authorize Spine & Rehab Associates, PLLC and all of its providers, staff, and third-party designees providers to discuss issues regarding my healthcare which may include, among topics not listed: visits, any lab or test results, my appointments or insurance with the following people and understand that this authorization will remain In effect until I notify the office in writing of any changes.

Name of Individual to release Information to: _____

Relationship: _____

_____ _____

Patient or Parent/Guardian Signature Date

AUTHORIZATION TO RELEASE MEDICAL RECORDS

- I hereby authorize the release of all my medical records to Spine & Rehab Associates, PLLC where necessary or as required for the purposes of my examination and/or treatment.
- I further authorize payment to be made directly to Spine & Rehab Associates, PLLC, as an assignment of my benefits, for services rendered that would otherwise be payable to me.
- I agree that in the event my outstanding bills are unpaid by a third-party source, I am responsible for payment of all services performed.

I have read and understand the above statements and attest that the information I have provided is correct.

_____ _____

Patient or Parent/Guardian Signature Date

AUTORIZACIÓN PARA DIVULGAR HISTORIALES MÉDICOS

- Por la presente autorizo la divulgación de todos mis registros médicos a Spine & Rehab Associates, PLLC cuando sea necesario o según se requiera para los fines de mi examen y/o tratamiento.

- Además, autorizo que el pago se haga directamente a Spine & Rehab Associates, PLLC, como una cesión de mis beneficios, por los servicios prestados que de otro modo serían pagaderos a mí.

- Acepto que, en caso de que mis facturas pendientes no sean abonadas por una tercera fuente, soy responsable del pago de todos los servicios prestados.

He leído y comprendo las declaraciones anteriores y doy fe de que la información que he facilitado es correcta.

_____ _____

FIRMA DEL PACIENTE/TUTOR FECHA

PATIENT PHOTO & VIDEO RELEASE

We love having the opportunity to serve patients like yourself and educate others on the services we offer at our practice. We ask for the ability to capture photos and videos for the following uses:

- Educational purposes (for teaching and/or training)
- Marketing or advertising (web, online ads, tv, print or social media)
- Company website

I [the patient or parent/guardian of the patient(s) listed above] hereby grant and authorize Spine & Rehab Associates, PLLC (herein after The Practice) the right to take, edit, alter, copy, exhibit, publish, distribute and make use of any and all photos and videos taken of me to be used in and/or for any lawful purpose.

-- This authorization shall continue indefinitely, unless I otherwise revoke this authorization in writing.

-- I waive the right to inspect or approve any finished product in which my likeness appears.

-- I agree to this release without being compensated. I waive any right to royalties or other compensation arising or related to the use of the photos or videos.

-- I hereby hold harmless and release The Practice from all liability, petitions, and causes of action which I, my heirs, representative, executors, administrators, or any other persons may make while acting on my behalf or on behalf of my estate.

I HAVE READ AND UNDERSTAND THE ABOVE.

_____ _____

Patient or Parent/Guardian Signature Date

ASSIGNMENT OF BENEFITS: ASSIGNMENT OF CAUSE OF ACTION: CONTRACTUAL LIEN

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered grants and conveys to:

Houston Center for Pediatric Therapy– 26865 Interstate 45, Suite 300 Houston, TX 77380
the following rights, power and authority:

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjuster for purposes of processing my claim for benefits and payment of services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owed by an insurance company in accordance with Article 22.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above, you are hereby tendered demand to pay in full the bill for services rendered by the physician/facility named above within 30 days allowing your receipt of such bill for services to the extent such bills are payable under the terms of the policy. This demand specifically conforms to Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. I further instruct the provider to make all checks payable to the above facility name and send all checks to the above address.

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the liability carrier to cut a separate draft to pay in full all services rendered, payable directly to the above facility name and send any and all checks to the above address.

STATUTE OF LIMITATIONS: I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered by the physician/facility named above, in addition to reasonable cost of collection, including attorney fees and court costs incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above the power to endorse my name upon any checks, drafts or other negotiable instrument representing payment from any insurance company for treatment and healthcare rendered by the physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named above.

REJECTION IN WRITING: I hereby authorize the physician/facility named above to establish a PIP or UM claim on my behalf. I also instruct my insurance carrier to provide upon request to the physician/facility named above, any rejections in writing as they apply to my lack of PIP or UM/UIM coverage. If my carrier is unable to provide said rejections in a timely manner, I acknowledge that I am entitled to minimum levels of coverage, as per section 1952.152 of the Texas Insurance Code, and further instruct my carrier to pay up to available limits directly to the physician/facility named above, and send any and all checks or financial instruments to, the address listed above.

TERMINATION OF CARE: I hereby acknowledge and understand that if I do not keep appointments as prescribed to me by my treating physician at this facility, he/she has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If, during the course of my treatment, my insurance company requires me to take an examination from any other doctor; I will notify this physician/facility immediately. I understand that failure to do so may jeopardize my case.

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE

PATIENT UNDERSTANDING AND ACCEPTANCE OF RISKS ASSOCIATED WITH TREATMENT

Spine & Rehab Associates, PLLC specializes in multi-disciplinary, conservative health care management and treatment of neuromusculoskeletal complaints - associated pain, physical impairment, and dysfunction. With our unique coordinated care model, our providers are able to treat a variety of ailments through the use of chiropractic care, physical therapies, behavioral therapy, speech therapy, occupational therapy, and medical pain management.

Although our practitioners are highly trained and skilled, certain therapeutic interventions/procedures that might be recommended and utilized in the treatment of your condition, could have inherent risk of injury. By informing you of these risks, we are striving to more actively involve you in your care plan and your care, as well as further assist you in making well informed decisions regarding your treatment options.

PASSIVE MODALITIES: Passive modalities consist of the following treatments: hot packs, cold packs, ultrasound, electrical stimulation, massage, traction and cold laser. The primary risks associated with passive modalities include electrical burns and skin irritation due to exposure to heat, cold or other agents used in the application of modalities (i.e. lotions and electric stimulation pads). If you have experienced skin sensitivity to heat, cold temperatures and/or lotions or similar products in the past, or are aware of any skin allergies, please inform our staff prior to treatment so proper precautions can be made prior to initiating treatment.

THERAPEUTIC INTERVENTIONS: Therapeutic interventions may consist of the following types of treatments (although this is not an exhaustive list): stretching, flexibility exercises, strengthening exercises, joint mobilizations and myofascial release. Therapeutic interventions are generally quite safe, though there are risks associated with each of these procedures. The primary risk is potential aggravation of your current condition and/or underlying condition. As with any physical activity and/or exercise, there is also the risk of injury. Though this risk Is minimal, as you are under the supervision of experienced clinical staff, it may still exist. Some responses to therapeutic interventions are muscle soreness, muscle fatigue, increased discomfort, overall tiredness and/or joint stiffness and/or pain. It is important that you inform your treating staff member of any of these responses following your treatment and more importantly, it is crucial that you continue to attend your appointments as scheduled so your condition can be documented and your symptoms effectively managed.

SPINAL MANIPULATION: Spinal Manipulation consists of adjustments that seek to restore normal function to the spine and other joints. Typically, this involved applying a specific, highly controlled treatment directly to a joint or muscle. This treatment often reduces or eliminates both local and referred pain, allows muscle spasms to relax and may even release the Irritation from the nervous system, which may result in other health benefits. As with any healthcare service, there are potential reactions and risks, however as with any healthcare intervention, it is hoped that the expected benefits of spinal manipulation exceed the expected risks. These are unavoidable risks of spinal manipulation which, though rare, can occur.

DISC HERNIATION: The occurrence of disc herniation during spinal manipulation is highly unlikely. In fact, averaged discs withstand an average of 23 degrees or rotation and degenerated discs an average of 14 degrees of rotation before failure occurs. Furthermore, given the fact that during manipulation posterior facet joints limit rotation to a maximum of 23 degrees, this joint would have to fracture to allow any further rotation to occur.

CAUDA EQUINA SYNDROME: It is estimated that the rate of occurrence of the Cauda Equina Syndrome as a complication of lumbar spinal manipulation is about one case per 100 million manipulations. It Is probably higher in patients with a herniated nucleus pulposus and lower in patients without this anatomic abnormality.

VERTEBROBASILAR ARTERY COMPROMISE: Serious complications of cervical spine manipulation are also rare (none have been reported in any of the clinical trials) but appear to be more common and severe than complications of lumbar manipulation. The most serious complication of the cervical spine manipulation is related to compromise of the vertebrobasilar artery, leading to stroke or death. The risk Is higher for manipulation Involving rotation plus extension of the vertical spine than for other types of manipulation and those persons who have suffered manipulation related vertebrobasilar artery compromise due to atherosclerotic disease. The best estimate of the incidence of vertebrobasilar artery compromise related to cervical spine manipulation is that it occurs one in a million manipulations (Hurwitz, 1996; McGregor, 1955).

As your healthcare provider, it is our responsibility to inform you of the potential risks and benefits of your treatment, but we also want to assure you that we strive to minimize these risks by providing thorough clinical examination and by performing diagnostics as clinically Indicated. Furthermore, we continually review medical literature pertaining to current trends within our profession as well as throughout the entire medical community to ensure the safest and most effective care.

_____ _____

Patient or Parent/Guardian Signature Date