THE
NERVE HEALTH
INSTITUTE
DR. CHRIS CORMIER, D.C.

108 Republic Ave. Suite B Lafayette LA 70508
phone (337) 456-6555 | email drc@nervehealthinstitute.com
www.nervehealthinstitute.com

CONSENT TO THE USE & DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

Patient's Name: _____ Id #: _____

I understand that this information serves as:

- A basis for planning my care and treatment.
- A mean of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment.

by which a third party payer can verify that services billed were actually provided.

- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon

I request the following restrictions to the use or disclosure of any healthcare information:

_____
_____
_____
_____
_____

Patient's (Legal Representative) Signature:

_____

Date: _____ Witness Signature: _____

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Informed Consent for Examination and Treatment

I (we) hereby consent to the performance of examination and treatment on me or on _____, by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists who may be employed by or engaged in practice in
this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below,

I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____.

_____ _____
Patient's Name (Print) Patient's / Guardian's Signature

_____ _____ _____
Date Relationship (if not signed by patient) Witness

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INFORMED CONSENT TO PARTICIPATE IN ACTIVE REHABILITATION

THE GOALS OF THE REHABILITATION PROGRAM INCLUDE:
1. Determining the cause and extent of your problem.
2. Providing a therapeutic exercise program to strengthen you, increase your cardiovascular endurance, range of motion and flexibility, and decrease your pain.
3. Return you to full-duty, non-restricted work status and lifestyle.

THE EQUIPMENT USED TO TEST YOU AND THE PROCESS WE WILL BE USING WILL BE EXPLAINED TO YOU. Your participation in the rehabilitation program is voluntary. You can stop at any point in the program.

Should you stop your program, we are obligated to notify your doctor, insurance company, attorney, and DVR manager, if it is applicable.
If at any point during the evaluation or rehabilitation process you have any questions, we will answer them to the best of our ability or refer you to someone more qualified. Please be advised that there are no guarantees that your personal goals and/or those listed above will be met to your satisfaction.

The success of any rehabilitation process lies in the combined efforts of you and your provider. The "team" approach has the best chance of attaining your goals, so please ask as many questions as necessary for you to gain the maximum benefit from your rehabilitation program.

Since the process of strengthening and conditioning are a form of "controlled strain", there is a chance of aggravation or injury. It is therefore imperative that you communicate to your provider any aggravation or injury that you may observe during the rehabilitation process. For example, the *best*
exercise for you, if performed too early in your condition, may be your *worst* enemy if performed too soon.

Communication with your provider will help put into perspective problems that may occur. Failure to discuss problems may only foster additional problems down the road.
I HAVE READ THE ABOVE AND UNDERSTAND THE RISKS AND BENEFITS OF THE REHABILITATION PROGRAM. I AGREE TO PARTICIPATE AND HAVE MY REHABILITATION INFORMATION RELEASED TO MY DOCTOR, INSURANCE CARRIER, ATTORNEY, OR DVR PERSONNEL IF REQUESTED.

_____ _____ _____
SIGNATURE OF PARTICIPANT DATE SIGNATURE OF WITNESS

RESEARCH CONCERNING THE REHABILITATION PROGRAM AND RESULTS MAY BE CONDUCTED. DATA WILL BE USED FROM THE PARTICIPANT'S EVALUATIONS AND EXERCISE PROGRAM. NO NAMES WILL BE USED AND ALL INFORMATION IS STRICTLY CONFIDENTIAL. PLEASE INITIAL BELOW.

_____ I AGREE TO PARTICIPATE _____ I DO NOT WISH TO PARTICIPATE

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Appointment Reminders and Health Care Information Authorization

Your chiropractor and members of the practice staff may need to use your e-mail address, name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by 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 these reminders and information.

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, you revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released you health information before we receive your request to revoke your authorization. In addition, if you were required to give you 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 who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this information. 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, information about treatment alternatives, or other health information at any time (164.524).

This notice is effective as of April 14, 2003. This authorization will expire six years after the date on which you last received services from us.

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/Title printed	Personal representative signature

Patient Intake Form

Are you a candidate for laser therapy?

Laser therapy is an FDA cleared modality for the treatment of pain and inflammation and the temporary increase of microcirculation. Increased microcirculation can provide relief for many acute and chronic conditions. This form is a tool to help your clinician determine if you are a candidate for laser therapy. If you answer yes to any of these questions you will need to discuss details of your condition with your clinician.

Please check **YES** or **NO** to the questions below

YES ☐ NO ☐ Do you have a pacemaker or any other implanted devices?

YES ☐ NO ☐ Are you pregnant?

YES ☐ NO ☐ Do you have cancer?

YES ☐ NO ☐ Are you taking medications that may increase your sensitivity to light?

YES ☐ NO ☐ Have you had a steroid injection in the last 7 days?

_____ _____

Patient Signature **Date**

_____

Print Patient Name

Notes:

The ultimate decision to recommend treatment lies with your health care provider.
Speak with your health care provider if you have further questions about therapy treatment.

Informed Consent

Laser therapy is a safe, non-invasive, FDA cleared modality for the treatment of pain and the temporary increase of microcirculation. Increased microcirculation can provide relief for many acute and chronic conditions. Laser therapy utilizes visible and invisible laser radiation, therefore, appropriate eye protection is required at all times during treatment.

Effects of your treatment will continue for up to 18 hours. Individuals respond uniquely to treatment, you may see immediate results after the first treatment or depending on the severity of your condition you may require several treatments before you begin to feel results.

Increased soreness may occur after your *first* laser session. This is a normal healing phenomenon known as retracing. Mild bruising may occur from the soft tissue manual therapy element of your treatment program.

You are required to complete the Patient Intake Form prior to treatment to ensure that laser therapy is a viable option for you.

☐ I understand the above and consent to treatment

☐ I understand that failing to complete any part of my treatment program will reduce my chances of success.

Patient Signature _____ Date _____

Print Patient Name _____ Physician Signature _____

INSTITUTE

Insurance companies do not pay for everything, even some care that you or your health care provider have good reason to think you need.

- Please read this notice so you can make an informed decision about your care.
- Ask any questions that you may have after you finish reading.

Dr. Cormier, Dr. Miller, and their staff will be providing the following services as they see fit:

Quantum Neurology Technique ($25): Quantum Neurology® Rehabilitation is a method of exercising and strengthening the Nervous System. This is done by incorporating neurological activation, physical mobilization and light therapy. Using a patented system of evaluation and correction, we find hidden neurological weaknesses in the body. Specific techniques allow us to activate the Nervous System's innate healing power so that the body can heal itself. The light therapy is Low Level Laser Therapy and uses a GRT Lite® with red and infrared light to strengthen deficits in the Nervous System.

ZYTO® Nerve Scan ($10): The hand cradle is a medical device cleared by the U.S. Food and Drug Administration to measure the patient's Galvanic skin response. The Nerve Health Institute has written a specific program for ZYTO that pre-screens the patient's nerves and stressors for the doctor prior to treatment. It is not cleared for diagnoses and treatment, it is simply a screening tool.

Aspen Class IV LASER Therapy ($30): High Intensity Laser Therapy is recognized by the FDA as a safe and effective treatment for a multitude of conditions and injuries. High Intensity Laser Therapy can help to reduce inflammation, increase blood flow, stimulate tissue growth, and help aid the body's own healing process without drugs or invasive procedures.

I want the above service(s). I understand that I will be asked to provide payment at time of service. Charges incurred will total $65 and will be in addition to any co-pay, co-insurance, or Personal Injury/Worker's Compensation charges.

I understand that insurance does not recognize nor does it cover these services and I am FULLY responsible for the charges incurred for these services.

Signing below means that you have received and understand this notice.
You may also receive a copy.
If further explanation is needed, please see a staff member to assist you.

Patient's Signature: _____ Date: _____

Patient's Name (Print): _____

24 Hour Cancellation Policy

The Nerve Health Institute maintains a rescheduling/cancellation policy of at least 24 hours notice prior to your next appointment. If an appointment is missed, canceled, or rescheduled with less than 24 hours notice, there will be a charge of $50.00.

While we understand that things come up often in life, we must maintain efficiency in our scheduling. Our clinic does not over-schedule per blocked time. We often have a waiting list of patients that need to come in and we prefer to be able to schedule someone beforehand rather than after a last minute cancellation. Our policies are put in place in an effort to better serve you!

By signing below, you acknowledge that you have read and understand the Cancellation Policy for the Nerve Health Institute as described above.

We appreciate your understanding and cooperation.

_____ _____

Patient or Guardian Signature Date