DATE: _____

TRUECARE™

PATIENT CONSENT TO TREAT FORM

Patient Name	DOB	Sex	Social Security Number
First Middle Last	mm/dd /yy	M F	- -
Address (☐ Same as Guarantor)	**Phone Number (** ☐ Same as Guarantor)		

ACKNOWLEDGMENT OF RECEIPT OF TrueCare WELCOME PACKET

We understand that information about you and your health is confidential, and we are committed to protecting your health information. As a patient you are required to review and sign this consent form prior to receiving care. Your authorization allows TrueCare staff to use your health information for treatment, payment, and our health care operations. Additional information regarding protection of your medical information can be found in the Notice of Privacy Practice that is included in this packet or may be found on our TrueCare website.

Items contained in the Welcome Packet are available on the TrueCare website, www.truecare.org for your reference. Welcome Packets are provided to new patients, however, if you would like one or have any questions, please ask for assistance from our front desk employees.

NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices, or a copy was made available to me.

TREATMENT, REFUSAL OF TREATMENT, and DISCLOSURE OF HEALTH INFORMATION

I, (the patient, responsible party, or authorized caregiver), authorize TrueCare and its assigned clinical staff to administer and perform all medical treatment, diagnostic, surgical or other services deemed advisable or necessary for healthcare. This care may be delivered either in person or through a virtual health modality. I understand that I have the right to refuse treatment at any time. I can do so by signing a *REFUSAL OF TREATMENT* form. I also give consent to use and disclose health information necessary for treatment and payment and other healthcare operations.

Minor (Patient who are <18 years of Age), Please list both parents or legal guardians:

Mother Full Name: _____ _____ DOB: _____
Father Full Name: _____ _____ DOB: _____
Other, Full Name: _____ _____ DOB: _____
Relationship to Patient: _____

ELECTRONIC COMMUNICATION

I, (the patient, responsible party, or authorized caregiver), authorize TrueCare and its clinical staff to communicate with me via my MyChart account by providing visit summaries and Lab results electronically, as well as sending and receiving secure messages. I understand that web-based communication is offered as an option, and I may choose not to register with MyChart.

DATE: _____

Patient Label

COMMUNICATION

I, (the patient, responsible party, or authorized caregiver), authorize TrueCare and its clinical staff and any affiliate or agent of TrueCare to contact me or others identified below as a member of my health support group on our cell phones and/or home phones, using pre-recorded messages, artificial voice messages, automatic telephone dialing systems, text messages, SMS messages, or other computer assisted technology. I understand that my service provider may charge for such communications and that standard message and data rates may apply. I understand that I am not required to consent to such calls or messages as a condition of receiving medical service. If I do not wish to receive communications at the address or phone number above, I will ask a TrueCare staff member to provide me with a *REQUEST TO CHANGE COMMUNICATION PREFERENCES* form.

HEALTH CARE SERVICE VIA TELEHEALTH

I, (the patient, responsible party, or authorized caregiver) understand that I have the right to access services through an in-person, face to-face visit or through telehealth. I understand there are Translation services and Transportation services available for services received through TrueCare. The use of telehealth is voluntary, and I may withdraw my consent to, or stop receiving services through telehealth at any time without affecting my ability to access covered services in the future. I understand that I have options to receive services in person face-to face or via telehealth. If I choose to receive services from TrueCare now or in the future via telehealth, I understand there may be potential limitations and risks related to receiving services via telehealth as compared to an in-person visit. If I have additional questions related to telehealth services, I understand the importance of addressing them with a TrueCare staff member.

USE OF AUDIO RECORDING

TrueCare may conduct audio recording of the words said during your visit for use in generating the medical record, to update your medical record, and provide you with information on potential diagnoses and treatment plans. These AI-based tools are an aid to the patient and the provider, but ultimately the provider will make a clinical decision using their own professional judgment. You can decline the audio recording and use of AI-based tools to generate notes at each visit. Information collected during the clinical encounter using these AI-based tools, may be relied on by the provider and become part of the patient's medical record. Such information is stored in compliance with the Health Insurance Portability and Accountability Act, as amended by the HITECH Act, and in accordance with their implementing regulations (collectively, "HIPAA") and other applicable state and federal law and may be used for TrueCare's healthcare operations to further improve the AI model for its patient population.

PERMISSION TO SHARE HEALTH INFORMATION (Optional)

As your healthcare team, we may need to contact you about your health. We would like to invite you to include members of your family and/or others to be part of your health support group. The people you identify will be permitted to discuss your health information, including but not limited to appointment information, lab results, medication instructions, and referrals information, and they may be contacted for follow-up in case we are unable to reach you. Please provide accurate information for any individuals designated as part of your health support group. Designated persons must show valid photo ID when in a clinic. **To request a paper copy, please complete the PATIENT ACCESS REQUEST FOR HEALTH INFORMATION FORM.**

DATE: _____

Last Name, First Name	Date of Birth MM/DD/YYYY	Contact Information		Relation to Patient	*Sensitive Health Information
		Phone #			☐ Yes ☐ No
		Address			
		Phone #			☐ Yes ☐ No
		Address			
*Permission to **Share Sensitive Health information** includes mental health treatment information, HIV test results, alcohol, or drug treatment information.					

AFFIRMATION OF UNDERSTANDING

My signature below confirms my understanding of TrueCare Consent to Treat.

_____ _____

Patient's/ Parent or Legal Guardian Signature **Date:**

Relationship to Patient: _____ **Copy of legal documents must be scanned into patient's account.*

TrueCare USE ONLY

☐ **Verbal Consent obtained during Virtual Visit.** By Signing below, I acknowledge I have reviewed each section with the patient and "Obtained Verbal" consent to sign on the patient's behalf.

TrueCare Staff Name (PRINT) _____ Sign _____ Date _____

TrueCare™

Guarantor Information Form

The following information is required annually for each patient. Please note that all information is confidential.

Patient Information			
Last Name	**First Name**	**MI**	**Date of Birth**

Guarantor Information (Responsible Party):			
Patient Relationship to Guarantor: *REQUIRED ☐ Self ☐ Mother / Father ☐ Legal Guardian ☐ Spouse ☐ Other:			
Is the Guarantor a TrueCare Patient: *REQUIRED ☐ Yes ☐ No			
Is the Guarantor Employed ☐ Yes ☐ No			
Family Size, including myself _____	**Annual Household Income** $_____		
If the Guarantor is not the patient, please fill out the next section:			
Last Name	**First Name**	**MI**	**Date of Birth**
SSN	**Birth Sex** ☐ Male ☐ Female		
☐ **Address and Phone # are the same as patient**			
Address **Apt./Unit**	**City**	**State**	**Zip Code**
Please check primary phone ☐ Home ( )	☐ Cell ( )	☐ Work ( )	

List TrueCare Patients who share the Same Guarantor		
PATIENT NAME (First/Last)	**Date of Birth (mm/dd/yy)**	**Guarantor Relationship to Patient**

Assignment of Benefits

I hereby authorize the release of medical or any other information necessary to my insurance carrier(s), or agent thereof to satisfy claims processing. I also authorize payment of medical benefits to TrueCare for services provided.

Guarantors/Patient's Signature:_____ **Date:** _____

*(Parent, Guardian, Power of Attorney, or Caregiver). *Copy of legal documents must be scanned into patient's account.*

[TrueCare Use Only]: Verbal consent obtained during a Virtual Visit or Written Consent via Legal Documentation.

☐ Staff reviewed each section with the patient and obtained verbal or written consent to sign on the patient's behalf. **Staff Initials ( )**

☐ Documentation obtained and scanned in patient chart: **CA Form 6910 Filed OR**

Patient Label Here

Chiropractic Patient History Form

Date: _____ Occupation: _____ How Long: _____

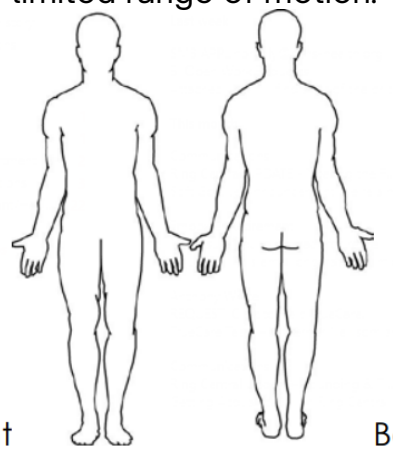
1) Have you received chiropractic services before? ☐YES ☐NO If yes, when?_____

2) Reason for today's visit: ☐Pain ☐Discomfort ☐Stiffness ☐Injury Other:_____

3a) Today, the condition is: ☐Same ☐Better ☐Worse **4)** When did your complaint(s) first begin?

3b) In general, your pain level is: 0 1 2 3 4 5 6 7 8 9 10 _____
(NO PAIN) (Worst Pain)

5) Use the figures below to place an "X" on any specific area(s) where you are experiencing pain, discomfort or limited range of motion:



6) Have you experienced these complaints before?
☐YES ☐NO If yes, when?_____

7) Explain what helps and/or worsens the condition:_____

8) Are you pregnant? ☐YES ☐NO ☐Not Sure

9) Any car accidents or work related injuries in the past?
☐YES ☐NO If yes, when?_____

10) Please check all medications (over the counter and/or prescribed) you are currently taking:
☐Aspirin ☐Pain Killers ☐Muscle Relievers ☐Other:_____
☐Birth Control Pills ☐Sleeping Pills ☐Anti-Depressants

11) List any major illnesses or any surgeries and years:
_____
_____

12) Check all symptoms/conditions you had even if they do not seem related to your current problem:
- ☐Stroke/TIA
- ☐Fractures/Dislocations
- ☐Prothesis
- ☐Pacemaker
- ☐Bleeding Disorders
- ☐Heart or Vascular Surgery
- ☐Cold Feet/Hands
- ☐Cancer/Chemotherapy
- ☐Loss of Balance/Fainting
- ☐Osteoporosis/Thin Brittle Bones
- ☐History of Pinched Nerve
- ☐Slipped/Herniated Disc
- ☐Head Injuries/TMJD

13) Check any of the following that you have currently or in the past year:
- ☐Headaches/Migraines Problems
- ☐Numbness/Tingling Arms or Hands
- ☐Blood Pressure Problems
- ☐Neck Pain
- ☐Numbness/Tingling Legs or Feet
- ☐Prostate/Sexual Dysfunction
- ☐Back Pain
- ☐Sinus Congestion/Allergies
- ☐Menstrual Cycle Dysfunction/Urinary Problems
- ☐Hip Pain
- ☐Lung Problems/Congestion
- ☐Frequent Nausea/Vomiting

STOP

FOR OFFICE USE ONLY

Clinician Reviewed:_____ Date:_____

Informed Consent to Chiropractic Treatment

Patient Label:

The Nature of Chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Would you like a staff member to accompany you for your visit? Yes ☐ No ☐

Possible Risks: As with any health care procedure, complications are possible following a chiropractor manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in a conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: ***I have had the following unusual risks of my case explained to me. I have read the explanation above of chiropractic treatment. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.***

Print Name	Signature of Patient or legal Representative	Date

WITNESS:

Print Name	Signature	Date