C.A.S.T.

10225 W. Higgins Rd ▪ Rosemont, IL 60018 ▪ (847) 825-2278
www.castwellness.com

Authorization to Release Medical Records

Dated this _____ day of _____, 202__

I hereby authorize and request _____

_____

_____

_____

To release the complete medical records and reports in your possession to:

Chiropractic and Strength Training
10225 W. Higgins Rd.
Rosemont, IL 60018
Fax: (847) 825-2279

____ All medical records regarding the treatment of the patient named below

____ All x-rays and reports of the _____

____ All MRI or other imaging studies of the _____

____ Other: _____

_____ _____

Patient Name Patient/Guardian Signature

_____

Patient D.O.B.

C.A.S.T.

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Authorization to Release Medical Information

Dated this _____ day of _____, 202__

I hereby authorize **CHIROPRACTIC AND STRENGTH TRAINING** to release to:

_____

_____

_____

_____

____ All medical records regarding the treatment of the patient named below

____ All x-rays and reports of the _____

____ All MRI or other imaging studies of the _____

____ Other: _____

_____ _____

Patient Name Patient/Guardian Signature

_____

Patient D.O.B.

C.A.S.T.

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Consent for Use or Disclosure of Health Information

Privacy Pledge

We are very concerned with protecting your privacy. The law requires us to give you a copy of our privacy notice. You can be confident that we always have and always will respect the privacy of your health information. There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services
- We may need to use your health information within our practice for quality control or other operational purposes

Along with this consent form, you will be offered a copy of this privacy notice that describes our privacy policies in detail. You have the right to review the notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail.

You have the right to request that we do not disclose your health information to specific individuals, companies or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, we are bound to that agreement.

You may revoke any of your authorizations at any time. However, your revocation must be in writing. We will not be able to honor your revocation if we have already released your health information before we receive your request. 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.

I have read your consent policy and agree to its terms. I am also acknowledging that I have been offered a copy of this consent form/privacy notice.

Patient Name (printed)	Patient Signature	Date
Parent/Guardian Name (printed)	Patient/Guardian Signature	Date

Witness Signature

C.A.S.T.

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Informed Consent

Patient Name (printed) _____ Date _____

As a patient in our office, you have the legal right to know of the type of treatment we will use, any potential complications/side effects, as well as alternatives to chiropractic care and their potential complications. This form is intended to inform you of these. Treatment cannot be given until you understand these aspects of care and sign this form. If you have any questions after reading this form, please ask Dr. Eickenberg.

The primary treatment used by Doctors of Chiropractic is spinal adjustment (manipulation) to reduce spinal subluxations (slight misalignment of the spinal joints). Dr. Eickenberg may use that procedure to treat you and/or recommend other common secondary treatments such as physical therapy modalities.

The nature of the chiropractic adjustment: Dr. Eickenberg will place his hands upon your spine in such a way as to move your spinal joints to restore joint play. This procedure may cause an audible "pop" or "click"; like what you feel when you crack your knuckles. You may feel or sense movement of the joint, which usually gives you a very pleasant sense of relief. If a traditional spinal adjustment is inappropriate for your condition, there are other types of adjustments that may be used. If, from previous experiences, you prefer non-traditional types of spinal adjustments, please inform Dr. Eickenberg beforehand.

While serious complications only occur one to two times per one million adjustments, there is a slight risk such as fracture, disc injury, dislocation, muscle strain, Horner's Syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. You may feel some stiffness or soreness following the first few days of treatment, which is considered normal.

The probability of those risks occurring: Fractures, especially of the ribs, are rare occurrences and generally result from some underlying weakness of the bone such as osteoporosis. If you suffer from osteoporosis, please let Dr. Eickenberg know.

Stroke has been the subject of tremendous debate within the health professions. Usually there is any underlying vascular condition like atherosclerosis that contributes to a stroke resulting after a neck adjustment. Some types of manipulation of the neck have been associated with other injuries to the arteries in the neck leading to a stroke in rare instances - along the lines of one case per three million. Mortality from spinal adjustments is three cases per 10 million.

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Disc injuries are frequently and successfully treated by chiropractic adjustments. However, occasionally chiropractic treatment may occasionally aggravate the problem. , surgery may become necessary if symptoms are not at least starting to improve within four weeks. If need be, Dr. Eickenberg will refer you to a neurosurgeon or for an MRI examination.

Ancillary treatments: In addition to chiropractic adjustments, Dr. Eickenberg may use the following treatments to control your pain or to enhance spinal stabilization.

- *Ice packs.* We may use ice packs and recommend ice for home use. This may irritate or burn your skin if over-used (typically more than 20 minutes) without a layer of clothing between your skin and the ice pack. The results are usually temporary and occur so rarely there are no available statistics to quantify their probability
- *Electrical stimulation therapy.* This modality consists of mild electric current which sends a massage-type action through the muscles and nerves to relax constricted muscles, block pain impulses, reduce swelling and facilitate healing in muscles and ligaments. There are no known side effects. Possible complications include irritation or skin burn.
- *Therapeutic ultrasound.* This treatment is the transmitting of sound waves into soft tissue to control swelling, break up tissue adhesions, sedate nerves, and speed the progression of healing. Possible complications include periosteal burn, soft tissue burn, or cavitation of tissue.
- *Therapeutic exercise.* This treatment is provided to restore optimal tissue coordination, strength and flexibility. The frequency, duration, intensity, and type of exercise prescribed are determined by the nature of the condition and its severity. A common side effect of exercise includes soreness. However, significant overtraining can lead to muscle/tendon strain and irritation. If pain occurs at any time, please inform Dr. Eickenberg to prevent overtraining.
- *NSAIDs.* Non-steroidal anti-inflammatory drugs may cause gastrointestinal problems in 1,000-4,000 people per one million. 16,500 people reportedly die annually from their use.

Patient Name (printed)	Patient Signature	Date
Parent/Guardian Name (printed)	Patient/Guardian Signature	Date

Witness Signature