Cypher Chiropractic & Rehabilitation Center
22636 Glenn Drive, Suite 204
Sterling, VA 20164
703.481.9698 Fax: 703.481.9699

## Cypher Chiropractic Informed Consent to Chiropractic Treatment

Medical doctors, chiropractic doctors, osteopaths, and physical therapists that perform manipulation are required by law to obtain your informed consent before starting treatment.

I, ________________________________________________, do hereby give my consent to the performance of conservative non-invasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used. Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

**Soreness**: I am aware that like exercise it is common to experience muscle soreness in the first few treatments.

**Dizziness**: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

**Fractures/Joint Injury**: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with caution.

**Stroke**: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one millions to once in ten million treatments. Once in a million is about the same chance as being hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

**Physical Therapy Burn**: Some of the therapies used in the office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be temporary increase of pain and possible blistering. This should be reported to the doctor.

Tests will be performed on me to minimize the risk of any complications from treatment and I freely assume these.

**TURN PAGE OVER AND COMPLETE BACK OF THIS FORM**

## Treatment Results

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate that there is no certainty that I will achieve these benefits.

I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by Scott B. Cypher, D.C. or associates and such other persons of the doctor's choosing.

## Alternative Treatments Available

Reasonable alternative to these procedures have been explained to me including rest, home applications of therapy, prescription of over-the-counter medications, exercises and possible surgery.

**Medications**: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause of concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

**Rest/Exercise**: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bed rest contributed to weaken bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve or joint tissues.

**Surgery**: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, acquired hospital infection, or prolonged recovery.

**Non-Treatment**: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increase inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy. Mechanical spinal/joint problems usually worsen with time.

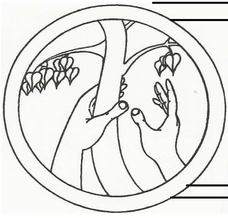
I have read or have had read to me the above explanation regarding chiropractic care. Any questions I have had regarding these procedures have been answered to my satisfaction before signing this consent form.

Signature of Patient: _______________________________________________ Date: ___________________

Printed Name of Patient: ____________________________________________________________________

If minor/Parent/Guardian Signature: __________________________________________________________

Date: _______________________________



# Cypher Chiropractic Centers, P.C.

## Scott B. Cypher, D.C. and Associates

Excellence in Chiropractic Since 1985
Member – American Chiropractic Association, Virginia Chiropractic Association

*Keeping You in Your Game of Life!*

**IRREVOCABLE ASSIGNMENT OF BENEFITS, AUTHORIZATION AND LIEN**

To Whom It May Concern:

This Irrevocable Assignment of Benefits, Authorization and Lien (this "Assignment") is made by and between __________________ ("Patient") and *Cypher Chiropractic and Rehabilitation Center* ("Health Care Provider"). With this Assignment, and in consideration of treatment without having to render concurrent payment, Patient, hereby irrevocably transfers sets over and assigns to Health Care Provider all insurance and/or litigation proceeds to which Patient is now or may hereafter become entitled, including those listed below, up to the total amount due and owing the Health Care Provider for services rendered to the Patient by reason of accident or illness, including interest thereon, as well as any other charges that are due or may become due the Health Care Provider, including, without limitation, requested reports, collection costs and expenses and attorneys' fees, and Patient further hereby irrevocably authorizes and directs any insurance company and/or attorney to whom an original or copy of this Assignment is provided to withhold from Patient and pay directly to such Health Care Provider such amount(s) from (1) any insurance benefits payable to Patient or on Patient's behalf, including, but not limited to, medical payments benefits, No Fault benefits, health and accident benefits, foundation grants, governmental or agency benefits, worker's compensation benefits or any other insurance proceeds or benefits of any kind which are payable to or on behalf of the Patient, and (2) any litigation proceeds (which may include insurance proceeds) from any settlement, judgment or verdict in Patient's favor as may be necessary to fully pay any and all financial obligations owed to the HealthCare Provider by the Patient. This Assignment is to be a complete and current transfer of Patient's right, title and interest, separate from any statutory or contractual lien or claim to which the Health Care Provider may also be entitled. Patient acknowledges that Health Care Provider has a substantial pecuniary interest in the enforcement of this Assignment.

The Patient further agrees that, in the event the insurance company and/or attorney obligated hereunder to make payments to the Health Care Provider fails or refuses to make payment for the full amount due as set forth above, this Assignment is a full, immediate and complete assignment of all of the Patient's rights, title, interest, remedies and benefits in and to the assigned property to the extent of the Health Care Provider's total claim amount; therefore, Patient hereby irrevocably and fully assigns and transfers to the Health Care Provider any and all causes of action that Patient might have or that might exist in Patient's favor against such insurance company and/or attorney with respect to the assigned property. In addition to the foregoing assignment, Patient hereby authorizes, nominates and appoints as Patient's attorney-in-fact any officer of the Health Care Provider, to prosecute said causes(s) of action either in Patient's name or in the Health Care Provider's name and Patient further authorizes the Health Care Provider to compromise, settle or otherwise resolve said claim(s) or cause(s) of action as it sees fit.

In further consideration of the services provided by the Health Care Provider, Patient hereby grants a lien to said Health Care Provider against any and all insurance benefits and litigation proceeds outlined in the first paragraph above which may be payable to or on behalf of the Patient as a result of the injuries or illness for which Patient has been treated by said Health Care Provider. The Patient further agrees that the statute of limitations applicable to Health Care Provider's right to demand payment from the Patient shall be tolled for all reasonable times that negotiations or litigation between third parties and the Patient are ongoing.

Patient hereby acknowledges that Virginia law imposes a lien in the amount of $750.00 upon Patient's claim against the individual or entity whose negligence is alleged to have caused Patient's injuries.

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22636 Glenn Dr. Suite 204, Sterling, VA 20164-4435 Phone: 703.481.9698 Fax: 703.481.9699

Notwithstanding the foregoing, the Patient agrees that until the Health Care Provider is paid in full, the Patient shall remain personally and fully responsible for and promises to pay the total amount due the HealthCare Provider (including principal, interest, collection costs and attorney's fees of 35%) until fully paid. The Patient further understands and agrees that this Assignment does not constitute any agreement of or consideration for the Health Care Provider to await payments from any source, and in the event the Health Care Provider deems itself in its sole discretion insecure as to the prospect of payment, it may demand payments from Patient immediately upon rendering services at its option and proceed to collect same through legal means if necessary.

Patient authorizes the Health Care Provider to release this Assignment and any information pertinent to Patient's case to any insurance company, adjuster or attorney to facilitate collection under this Assignment. Patient hereby nominates and appoints any officer of the Health Care Provider as Patient's attorney-in-fact to endorse/sign Patient's name on any and all checks for payment of any indebtedness owed by Patient to the Health Care Provider and to negotiate same for payment of the services provided to Patient by said Health Care Provider.

In the event that any part or provision of this Assignment shall be determined to be invalid or unenforceable, the remaining parts and provisions of this Assignment which can be separated from the invalid, unenforceable provision shall continue in full force and effect.

I authorize the Health Care Provider to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment. I hereby nominate and appoint ________________________________ as my attorney in fact to endorse/sign my name on any and all checks for payment of any indebtedness owed by me to Health Care Provider and to negotiate same for payment of the services provided to me by said Health Care Provider.

Witness the following signatures and seal as of the indicated date:

Patient:
Signature_____________________________________ (SEAL)

Printed Name__________________________________

Date____________ SS#______________________

Witness__________________________________

Health Care Provider:
Cypher Chiropractic & Rehabilitation Center

22636 Glenn Drive, Suite 204
Sterling, VA 20164____________________

By: ______________________________

Its: ______________________________

Date _________________

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**RECORDS RELEASE** **DATE: ________________**

**Patient Name: ______________________________ Date of Birth: ____________________**

**Doctor or Hospital: ____________________________________________________________**
**Phone #: _____________________________ Address: ______________________________**
**Fax#: _______________________________**

**I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:**

**Cypher Chiropractic & Rehabilitation Center**
**22636 Glenn Drive, Suite 204**
**Sterling, VA 20164**
**Phone: 703.481.9698**
**Fax: 703.491.9699**

**Or To__________________________________________(Doctor or Hospital)**
**___________________________________________(Address)**

**The complete records in your possession concerning my illness and/or treatment during the period.**

**FROM_____________________________________ TO_______________________________**
**Signature: __________________________________Witness:___________________________**

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**X-RAY/PREGNANCY**

**By my signature, I am stating that I am not pregnant at this time and consent to x-rays at Cypher Chiropractic & Rehabilitation Center. If I think I may be pregnant or am not sure, I will not sign this form for x-rays.**

**PRINT NAME: _________________________ SIGNATURE: _______________________**
**DATE: ________________________________ WITNESS: __________________________**
**DATE OF LAST MENSTRUAL PERIOD: ____________________________**

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## REQUEST FOR CONFIDENTIAL COMMUNICATIONS

**Name of Patient: ____________________________________________________**
**(please print)**

**Date of Birth: _______________________________________________________**

**I request that all communications to me (by telephone, mail or otherwise) by Cypher Chiropractic & Rehabilitation Center and/or its staff be handled in the following manner:**

- **For written communications: Address to: ________________________________**
  ________________________________________
  ________________________________________
  ________________________________________
  ________________________________________
- **For oral communications: Call: __________________________________________**

  **May we leave a message? _____ Yes ____No**
- **I give my permission to leave any medical information with the following people:**
  __________________________________________________________________
  __________________________________________________________________

**If the address provided above is not your home address or is not a street address, please provide us with a street address for the purpose of ensuring payment:**

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

___________________________ ___________________________
**Patient Signature** **Date**

**For Practice Use Only: ________Accepts _______Denies**
**Privacy Officer Signature: ____________________________________________________**

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# Vertebrobasilar/Cerebrovascular Questionnaire

Name: ___________________________________________ Date: ___________________

*Please answer the following questions as accurately as possible.*
*Check the appropriate response.*

- Did your neck pain/headache begin gradually? Yes ______ No ________ or
- Suddenly? Yes ___________ No __________
- Have you had these symptoms before? Yes _________ No ____________
- If yes, is this episode similar to ____________ or different then ___________ your prior episodes?
- If it is different, explain how:_______________________________________________
  ________________________________________________________________________
- Have you had any dizziness? Yes ___________ No ________
- Lightheadedness? Yes __________ No __________
- Have you had any trouble with your vision? Yes __________ No ________
- Have you had any trouble with your speech? Yes __________ No ________
- Have you had any trouble with your balance? Yes __________ No________
- Have you had any trouble with your coordination? Yes __________ No __________
- Have you had any trouble with swallowing? Yes __________ No __________
- Have you had any nausea or vomiting? Yes ___________ No ____________
- Have you had any numbness or tingling? Yes _________ No _____________

# Cypher Chiropractic & Rehabilitation Center

## Health History

NAME: ______________________________________ DATE:______________

Please review the listed conditions and indicate those that are current or past health problems of yourself or family members.

| CONDITION | SELF AGE ( ) | FATHER AGE ( ) | MOTHER AGE ( ) | SPOUSE AGE ( ) | BROTHERS AGE ( ) | SISTERS AGE ( ) | CHILDREN AGE ( ) |
|---|---|---|---|---|---|---|---|
| AIDS | | | | | | | |
| ARTHRITIS | | | | | | | |
| ASTHMA- HAY FEVER | | | | | | | |
| BACK TROUBLE | | | | | | | |
| BURSITIS | | | | | | | |
| CANCER | | | | | | | |
| CONSTIPATION | | | | | | | |
| DEPRESSION | | | | | | | |
| DIABETES | | | | | | | |
| DISC PROBLEM | | | | | | | |
| EMPHYSEMA | | | | | | | |
| EPILEPSY | | | | | | | |
| HEADACHES | | | | | | | |
| HEART DISEASE | | | | | | | |
| HIGH BLOOD PRESSURE | | | | | | | |
| HIV | | | | | | | |
| INSOMNIA | | | | | | | |
| KIDNEY DISEASE | | | | | | | |
| LIVER DISEASE --------------------- MENTAL ILLNESS | | | | | | | |
| MIGRANES | | | | | | | |
| NEURITIS | | | | | | | |
| PINCHED NERVE | | | | | | | |
| SCOLIOSIS | | | | | | | |
| SINUS TROUBLE | | | | | | | |
| ULCER | | | | | | | |
| TB | | | | | | | |
| OTHER | | | | | | | |

If any of the above family members are deceased, please list their age of death and cause.