Northwestern Health
Human Performance Center

Parents,

Welcome to another year of exciting athletic events! I would like to take this opportunity to introduce myself and the Northwestern Health Sciences University Human Performance Center.

My name is Dr. Kellen Otte. I am a Doctor of Chiropractic and Emergency Medical Technician, currently doing a fellowship at the Human Performance Center under the supervision of Dr. Timothy Stark. This will be our third year working with Concordia Academy, and I have had the privilege to work with this school all three years in some manner.

I will be available to students on campus twice a week; Mondays and Thursdays, from 2:00-5:00PM, and will be accompanied by a student intern with an interest in sports medicine. Our goal is to get your child competing at their best, and to provide exceptional health care when needed. The care we will provide is as follows:

- Performing functional and focused examinations on an area of injury
- Diagnose and create a treatment plan for injury recovery
- Provide primary sports care, including chiropractic services, to those who are evaluated and warrant care

If you need to get a hold of me, my contact information is provided below. If I am unavailable for any reason, feel free to leave a message and I will get back to you within twenty-four hours during the workweek.

I look forward to working with all of the athletes, and providing them with the care they need to get back on the field quickly and have a successful athletic year!

Sincerely,

Kellen Otte, DC, EMT

Office: 1-800-888-4777 x149

Email: kotte@nwhealth.edu

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INFORMED CONSENT FOR DIAGNOSIS AND TREATMENT

I hereby give my consent to performance of diagnostic tests and procedures and treatment or management of my condition(s). Chiropractic treatment or management of conditions almost always includes adjustments, a specific type of joint manipulation. Like most health care procedures, the chiropractic adjustment carries with it some risks. Unlike many such procedures, the serious risks associated with the chiropractic adjustment are extremely rare.

The Following are the known risks:

Temporary soreness or increased symptoms or pain: It is not uncommon for patients to experience temporary soreness or increased symptoms or pain after the first few treatments.

Dizziness, nausea, flushing: These symptoms are relatively rare. It is important to notify the chiropractor if you experience there symptoms during or after care.

Fractures: When patients have underlying conditions that weaken bones, like osteoporosis, they may be susceptible to fracture. It is important to notify your chiropractor if you have been diagnosed with a bone weakening disease or condition. If your chiropractor detects any such condition while you are under care, you will be informed and your treatment plan will be modified to minimize risk of fractures.

Disc Herniation or Prolapse: Spinal disc conditions like bulges or herniations may worsen even with chiropractic care. It is important to notify your chiropractor if symptoms change or worsen.

Stroke: A certain extremely rare type of stroke has been associated with chiropractic care. Although there is an association between this type of stroke and chiropractic visits, there is also an association between this type of stroke and primary care medical visits. According to the most recent research, there is no evidence of excessive risk of stroke associated with chiropractic care. The increased occurrence of this type of stroke associated with both chiropractic and medical visits is likely explained by patients with neck pain and headache consulting both doctors of chiropractic and primary care medical doctors before or during their stroke.

Other risks: Associated with chiropractic treatment include rare burns from physiotherapy devices that produce heat

Bruising: Instrument assisted soft tissue manipulation may result in temporary soreness or bruising

Standard primary sports care will be delivered at Concordia Academy by signing this document. Primary sports care includes taping, triage, ice, heat, ultrasound, and injury rehabilitation. Additionally,
Please initial below

____I elect to have my child receive chiropractic service in addition to standard primary sports care

____I do not elect to have my child receive chiropractic service in addition to standard primary sports care

Patient Please Review ●Print & Sign Name

I have read or had read to me this informed consent document. I have discussed or been given the opportunity to *discuss any questions or concerns with my provider and have had these answered to my satisfaction prior to my signing this informed consent document. I have made my decision voluntarily and freely.*

Patients Name (Print): ____ Date of Birth ______________

_____________________________________ ____________
(Patient/Guardian Signature) (Date)

Clinician Only

Based on my observation, the patient's history and physical exam, I conclude that throughout the informed consent process the patient was:

O Of Legal Age O Appears Unimpaired O Consent Given Through Guardian
O Oriented 3x O Fluent in English O Assisted by a Translator or Interpreter

_____________________________________, D.C. ____________ ____________
(D.C. Signature) (Date) (Intern Initial)

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AUTHORIZATION TO TREAT A MINOR & PRIVACY PLEDGE

Athlete's Name	Date

OUR PRIVACY PLEDGE: The NWHSU-Clinic System is concerned with and committed to the protection of our patients' privacy and ensuring the confidentiality of the personal health information entrusted to us.

Ways in which the University may use or disclose your health care information include, but not limited to:

- Another health care provider within the University Care system, or to another provider or facility for the purpose of diagnosis, assessment or treatment of you r health.
- The School Nurse, Athletic Director, or head coach, when such information may be relevant to participation in school sports activities.
- The use of that information within our practice for quality control or other operational purposes.
- Business associated that we contract with to perform a service for you and benefit and bill for it
- Research, when the University review board has reviewed the research proposal and established protocols to ensure the privacy of your health information.
- The use of that information to contact you by telephone, mail, or email with appointment reminders, information about the clinic facilities, treatment alternatives or health –related information that you may be of interest to you.

Along with this consent form, you will have access to a detailed copy of our privacy policies in the clinic or can be found online at nwhealth.edu. We reserve the right to change our privacy practices as described in the notice. The most current notice, including the effective date, will be posted in the clinic facility and on the university website, nwhealth.edu.

Your Right to Limit Uses or Disclosers: You have the right to request that we do not disclose your child's health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use disclosure of your child's health information please let us know in writing.

Your Right to Revoke Your Authorization: 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 request if we have already released your health information before we receive your request to revoke your 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.

YOU HAVE A RIGHT TO REFUSE CONSENT FOR DISCLOSURE OF YOU PERSONAL HEALTH INFORMATION. WITHOUT YOUR CONSENT, HOWEVER, THE NWHSU-CLINIC SYSTEM WILL NOT BE ABLE TO SUBMIT CLAIMS TO INSURANCE CARRIERS OR OTHER THIRD PARTY PAYERS AND MAY NOT ACCEPT YOU AS A PATIENT/CLIENT.

[ ] I acknowledge the NWHSU-notice of Privacy Practices

Authorization

I hereby request and authorize the performance of diagnostic tests, procedures, and treatment to my child. This authorization also extends to all other personnel in this clinic and is intended to include radiographic examination at the clinician's discretion. I understand that information about my child's case may be used in case presentations (name and other personal information is kept confidential).

As of this date, I have legal right to select and authorize health care services for the child named above.

(If applicable) Under the terms and conditions of my divorce, separation or other authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to select and authorize this care should be revoked or modified in anyway, I will immediately notify NWHSU.

Printed Parent/Guardians Name ____ Relationship _______________

Signature ____ Date ______________

ATHLETE DEMOGRAPHIC FORM

LEGAL NAME___________________________________ PREFERRED NAME________________________

DATE OF BIRTH __________________________________ O MALE O FEMALE OTHER ____________

ALLERGIES ____

MEDICATIONS ____

____

MAJOR ILLNESS/INJURES/SURGERIES: ____

____

SPORTS:

____

____

____

____

EMERGENCE CONTACT:

NAME ____

RELATIONSHIP: O PARENT O GUARDIAN O OTHER ____________

PHONE:

WORK ____

HOME ____

CELL ____