

Payment/Authorization/Consent Form

Payment:

I understand and agree that I am responsible for payment of all fees incurred by me or my dependent(s) at this office on a per visit basis. Should collection of past due amounts become necessary, I will become responsible for all incurred late charges and/or attorney fees associated with this past due amount. I hereby authorize this office to release all information necessary to secure payment of benefits. I authorize the use of this signature for all insurance submissions. Please understand that at times, your insurance company may forward payment of our fees to your residence. Please contact us if you do get insurance money sent to you so that we can determine what fees the payment is for.

Patient Signature _____ Date _____

Payment Authorization:

I direct and authorize my attorney and/or insurance company on this claim to pay directly to LifeStyle Chiropractic all such sums as may be due and owing for services rendered and/or supplies given me in the course of treatment.

Patient Signature _____ Date _____

Records Release Authorization:

I authorize this office to release my personal or dependent's medical records, or any pertinent information regarding my care to my insurance company, adjuster, attorney, hospital, or physician upon request and with a signed authorization release.

I authorize any medical facility to relinquish medical records, diagnostic reports or other pertinent information regarding mine or my dependents care to this office.

Patient Signature _____ Date _____

Non-Pregnancy Verification:

I understand that x-rays can be hazardous to an unborn child. I hereby notify all concerned, that I neither suspect nor know positively at this time that I may be or am pregnant.

Patient Signature _____ Date _____

X-ray Consent:

I understand the purpose of the x-rays to be taken is to analyze the spine for vertebral subluxations and to determine the appropriateness of chiropractic treatment. I consent to the chiropractic spinal x-rays determined to be medically necessary by the attending chiropractor.

Patient Signature _____ Date _____

Consent To Treatment Of A Minor:

I hereby authorize the attending chiropractor to administer treatment deemed necessary to my minor dependent.

Minor's Full Name _____

Legal Guardian Signature _____ Date _____

Informed Consent

We want you to be informed about the potential risks associated with chiropractic treatment, so that you may make an educated decision as to whether you accept these risks and want this form of treatment. Some of the risks involved in chiropractic treatment are discussed below.

Stroke:

A stroke occurs when a portion of the brain does not receive enough blood/oxygen. The results can be temporary or permanent neurological compromise, and in rare instances, death may occur. Chiropractic adjustments or manipulations have been associated with strokes that arise from vertebral artery compromise. Articles written on this subject estimate the incidence of this type of stroke to be about 1 in 400 thousand to about 1 in 5.8 million.

Disc Injuries:

Disc problems in the neck and back that cause pressure against a nerve, creating local or radiating pain, are frequently successfully treated by chiropractic adjustments. It is possible though for chiropractic treatment to aggravate an existing disc problem too. There aren't available statistics to quantify the probability of this happening.

Soft Tissue Injury:

Soft tissue primarily refers to the muscles, ligaments, tendons or connective tissue. It is possible for chiropractic treatment to injure soft tissue to a degree. This would be like a sprain/strain type injury. The result can be in the form of temporary pain, reduced function, spasming and/or bruising. This problem is typically treated to resolution and there are usually no long-term affects. These problems occur so rarely that there are no available statistics to quantify the probability of this happening.

Rib Fractures:

The ribs extend from your spine to your chest. A rib fracture can occur in osteoporotic patients and possibly patients with advanced arthritic changes in the spine.

Heat Therapy Burns:

We use moist heat packs and ice. Everyone's skin has a different sensitivity to these therapies. We attempt to take all precautions when using these therapies.

Soreness/Tenderness:

It is common for a patient to experience temporary tenderness or soreness following chiropractic treatment. This is typically a temporary symptom that occurs due to your body's experiencing change. This is not generally a cause for concern but please let the attending doctor know about it.

Diagnoses _____ Alternative Treatments _____

PURPOSE OF TREATMENT _____ SUCCESS/FAILURE _____ NO TREATMENT _____

Doctor Comments: _____

I hereby request and consent to the administering of chiropractic care and therapies as necessitated by the attending doctor. I understand that the practice of chiropractic care is not an exact science and that my care will involve decision making based upon facts known to the doctor at the time. I understand that it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications, and that an undesirable result does not necessarily indicate an error in judgment, negligence or the rendering of inappropriate treatment. I understand that no guarantee of the results has been made to me, and I wish to rely on the doctor to utilize his judgment during the course of treatment that he feels at the time, based upon the facts then known, is in my best interest.

Printed Name of Patient _____

Patient/Legal Guardian Signature _____ Date _____