PATIENT NAME: DOB: DATE:

**Insurance Authorization:**

* I authorize the release of any medical information necessary to process for private insurance and request payment of insurance to Thornton Chiropractic Center.
* I understand that my insurance will be filed as a courtesy to me. I also understand that the written terms of my contact between my insurance company and myself will apply to all billed charges. Thornton Chiropractic Center can only give me an estimation of these benefits. Determination of benefits is done by my insurance company after they receive the claim.
* I understand I am responsible for payment of all charges for services rendered to me by Thornton Chiropractic Center. The fact that I have insurance does not release me of my personal responsibility of payment.
* I understand that if my insurance has not made payment within 60 days from the date of service, I will be billed and responsible for the balance of my account.
* I hereby state and agree that a photocopy of this document will be deemed as valid and binding on all parties involved.
* I acknowledge that I am responsible for payment of all non-covered services.

**BILLING ACKNOWLEDGEMENT:**

* Under your health plan, you are financially responsible for co-payments, co-insurance and/or deductibles for covered services. You are also financially responsible for all non-covered services and any service that exceeds your benefit limit as defined by your health plan. Please complete the following information (applicable to your situation):

Primary Health Insurance: ID# Group#

Subscriber Name: Subscriber DOB:

Secondary Health Insurance: ID# Group#

Subscriber Name: Subscriber DOB:

Auto Insurance Carrier: Claim #:

Adjuster’s Name: Adjuster’s Phone #:

Attorney’s Name: Attorney’s Phone #:

* Medicare Patients: Please review the services/products listed below and take note of the non-covered items as determined by Medicare.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| NO | Examination | YES | Spinal Manipulations | NO | Muscle Stimulation |
| NO | Visit/Condition Limitations | NO | Extremity Manipulations | NO | Hydrotherapy |
| NO | X-Rays (in a chiropractic office) | NO | Orthotics | NO | Maintenance Care\* |

\*Maintenance Care is not covered by some health plans, including Medicare. Medicare will only cover spinal manipulations if medically necessary and the patient is experiencing an exacerbation. Spinal manipulations to maintain your spinal health are not covered.

I acknowledge that I have been told in advance that the services noted above as “NO” are not covered or may be limited by my health plan and agree to pay for these non-covered services.

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT NAME: DOB: DATE:

PATIENT NAME: DOB: DATE:

**HIPAA:**

* List family member(s) or other person(s), if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations.

Name: Phone Number:

Name: Phone Number:

Name: Phone Number:

* List address of where you’d like billing statements and/or correspondence from our office sent to:

* Would you like said correspondence to be labeled “CONFIDENTIAL” sealed envelope?
* List a phone # where we may leave messages regarding your health care information:
* I HAVE READ AND UNDERSTAND THE PRIVACY PROTECTION ACT (initial):

**FINANCIAL ARRANGEMENT:**

* Select any that apply to you:
* Private Pay: Account must be paid in full after each appointment.
* Medicare: Claims will be filed directly to Medicare. Any non-covered services will be paid by patient at time of service.
* Health Insurance: Claims will be filed directly to your insurance carrier. Patient is responsible for any co-pays, deductible or non-covered amount.
* Automobile Insurance: If you have been in an auto accident, we will file directly to your auto insurance company with an Assignment of Benefits signed by you. Patient is responsible for any applicable deductible or co-payment not covered by the PIP or other coverage.
* Attorney Representation: We will request a Letter of Protection from your attorney after your first visit at our office. This letter must be signed by the patient.

**MISSED APPOINTMENTS POLICY:**

* Chiropractic appointments must be cancelled at least 3 hours in advance. Less than 3 hours will be considered a no-show.
* **No-Show patients are subject to a $35 fee for missed chiropractic and massage therapy appointments.**
* Massage appointments must be cancelled at least 24 hours in advance. Less than 24 hours will be considered a no-show.

I would like text message appointment reminders directed to this phone #:

I have read and fully understand and agree to abide by the arrangements and policies that pertain to me. I furthermore acknowledge and agree that I am responsible for paying Dr Glen Thornton’s fees for treating me. Payment is due upon receipt of bill.

SIGNATURE: Date:

**INFORMED CONSENT:**

**To the patient:**  Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if anything is unclear.

**The nature of the chiropractic adjustment:** The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to restore function to your joints. That may cause an audible "pop" or "click" much as you have experienced when you "crack" your knuckles. You may feel a sense of movement. I also use other techniques that do not cause an audible "pop" or "click".

Analysis / examination / treatment:

As a part of the analysis, examination, and treatment, you are consenting to one or more of the following procedures:

spinal manipulative therapy palpation vital signs

range of motion testing orthopedic testing basic neurological testing

muscle strength testing postural analysis ultrasound

hot/cold therapy EMS radiographic studies (x-ray)

other

**The material risks inherent in chiropractic adjustment:** As with any healthcare procedure, there are certain complications which may (in the most extreme rare circumstance) arise during chiropractic manipulation and therapy. These complications may include but are not limited to: fractures, disc injuries, dislocations, muscle strain, costovertebral strains and separations, cervical myelopathy and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. None of these risks have ever occurred to any patient, as a result of, or during the course of treatment by Dr. Glen Thornton. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contradictions to care; however, if you have any condition that would otherwise not come to my attention, it is your responsibility to inform me.

The possibility of those risks occurring:

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history, examination and x-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare. The other complications are also generally described as rare. Again, none of these risks have ever occurred to any patient, as a result of, or during the course of treatment by Dr. Glen Thornton.

The availability and nature of other treatment options:

Other treatment options for your condition may include:

\*Self-administered, over-the-counter analgesics

\*Medical care and prescription drugs such as anti-inflammatory medication, muscle relaxants and pain-killers.

\*Hospitalization

\*Surgery

\*Rest

If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated:

Remaining untreated may allow the formation of adhesions and reduced mobility which may set up pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

Please check the appropriate block and sign below.

**I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment.** If I have questions, I will discuss them with Dr. Thornton. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

PATIENT SIGNATURE: Date:

SIGNATURE OF PARENT OR GUARDIAN (IF PATIENT IS A MINOR):

DOCTOR’S NAME: Dr. Glen S. Thornton, D.C.

DOCTOR’S SIGNATURE: Date: