HEALING RIVER
chiropractic

Provider: Dr. Kellie Seth
NPI: 1770048027
TIN: 46-3305571

Patient Financial Responsibility

This health care office is not a provider with any insurance. Since we will not need to pay staff to bill and follow up with insurance companies, we pass the savings on to you. We offer EVERYONE our Time of Service rates when their accounts are paid in full on each visit. A written copy of our fee schedule is available upon request.

Informed Consent for Chiropractic & Myofascial Treatment

I hereby request and consent to the performance of Chiropractic treatments (also known as Chiropractic adjustments or manipulative treatments) and any other associated procedures: physical examination, tests, nutritional therapy, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, etc. on me by the doctor of Chiropractic named above and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during Chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Horner's Syndrome, diaphragmatic paralysis, cervical myelopathy, and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor/practitioner to be able to anticipate all risks and complications, and I wish to rely upon the doctor/practitioner to exercise judgment during the course of the procedures(s) which they feel at the time, based upon the facts then known, are in my best interest.

Consent to Nutritional Testing/Care

I hereby request and consent to the performance of Nutritional testing/care, and I understand that Nutritional testing/care is meant to lessen or alleviate my current symptoms. I am solely responsible for providing complete and accurate information, and I understand that any misinformation or omitted information may affect the Nutritional testing/care I receive.

I acknowledge that I am responsible for my own health decisions, and any recommendations I follow for changes in diet including, but not limited to, the use of supplements are entirely my choice and my responsibility. I do not expect the doctor/practitioner to be able to anticipate all risks and complications, and I knowingly assume any and all risk to my health associated with Nutritional testing/care.

Summary

I have read the above explanation of the Chiropractic/Myofascial treatments and Nutritional testing/care. I have had an opportunity to discuss the nature and risk of Chiropractic/Myofascial treatments, Nutritional supplemental recommendations, and other recommended procedures. I have had my questions answered to my satisfaction.

I understand that specific results are not guaranteed. Healing River Chiropractic's doctors/ practitioners do not claim to diagnose or cure any disease. If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I state that I have been informed and weighed the risks involved in Chiropractic/ Myofascial treatment, as well as Nutritional care/supplemental recommendations given at this health care office.

I have decided that it is in my best interest to receive Chiropractic/Myofascial treatment or Nutritional testing/care. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

I have read and agree to the above.

_____

Patient Name (Printed)

_____ _____

Patient Signature Date

_____ _____

Signature of Representative (if applicable) Date