# ***HEALING RIVER CHIROPRACTIC***

1903 Greeley St S, Suite 100
Stillwater, MN 55082
651-439-3737

## ***PATIENT FINANCIAL RESPONSIBILITY***

This 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.

If you have been involved in an Automobile Accident and choose to treat here, we will bill the insurance company for you. If the insurance carrier does not cover your services you are ultimately responsible for any outstanding balance.

## ***INFORMED CONSENT FOR CHIROPRACTIC 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 to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedures(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose and risks of chiropractic treatments, nutritional/supplemental recommendations and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed. We 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

## ***Consent to Nutritional Testing/Care***

I hereby request and consent to the performance of Nutritional testing/care and acknowledge that I am responsible for my own health decisions. It has been explained to me that Nutritional testing/care is meant to lessen or alleviate your current symptoms. I have had an opportunity to discuss the nature and risk of nutritional supplemental recommendations. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed. We 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 America Arbitration Association guidelines.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgement during the course of the procedures which the doctor feels at the time, based upon the facts then known, that are in my best interest

## ***Summary***

I have read the above explanation of the Chiropractic treatments and or Nutritional care. I state that I have been informed and weighed the risks involved in chiropractic treatment, as well as nutritional/supplemental recommendations given at this health care office. I have decided that it is in my best interest to receive chiropractic treatment or Nutritional 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.

Sign only after you understand and agree to the above.

_____

Printed name of Patient

_____ _____

Signature of Patient Date

_____ _____

Signature of Representative (if patient is a minor/handicapped) Date

_____ _____

Witness to Patients Signature Date