INFORMED CONSENT TO EXAMINATION, CHIROPRACTIC ADJUSTMENTS, AND CARE

I hereby request and consent to the performance of Chiropractic adjustments and other Chiropractic procedures, including the various modes of physical therapy, examinations, diagnostic x-rays and massage therapy on myself or ______________________(for whom I am legally responsible) by licensed Doctors of Chiropractic and/or licensed Massage Therapists who are employed at Highlands Chiropractic Clinic.

I understand and am informed that, as in the practice of medicine, in the practice of Chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, sprains, dislocations, and stroke. I do expect the doctor to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of procedure which the doctor feels at that time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also been offered the opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by patient:

Patient's Name:____

Patient's Signature:____

Date: ____________________

To be completed by the patient's representative, if necessary, e.g. if the patient is a minor or physically or legally incapacitated:

Patient's Name:____

Name of patient's representative: ______________________________

Representative's Signature:____________________________________

As: ____

(Relationship to Patient)

Date: ____________________

ASSIGNMENT AND RELEASE

I AM FINANCIALLY RESPONSIBLE FOR SERVICES NOT COVERED BY MY INSURANCE. I AUTHORIZE THE DOCTOR TO RELEASE ANY HEALTH INFORMATION REQUESTED TO PROCESS MY INSURANCE CLAIMS; AND THAT MY CLAIMS BE PAID TO THE DOCTOR. I UNDERSTAND THAT PAST DUE ACCOUNTS MAY BE SUBJECT TO A LATE CHARGE OR FINANCE CHARGE. **ALSO, ANY CHARGES ASSOCIATED WITH A COLLECTION AGENCY WILL BE MY RESPONSIBILITY.** I AM AWARE THAT THE DOCTORS ROUTINELY SEND X-RAYS OUT FOR SECOND OPINION CONSULTATION AND THAT I WILL BE FINANCIALLY RESPONSIBLE FOR THOSE SERVICES.

____

Patient's Signature   Date

Highlands Chiropractic

3901 NE Fourth Street, Suite 109
Renton, WA 98056

Phone 425-277-0577
Fax 425-277-0652

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculosketetal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, ______________________________ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I, therefore, accept chiropractic care on this basis.

______________________________ ______________________
(signature) *(date)*

CONSENT TO EVALUATE AND ADJUST A MINOR CHILD

I,______________________________ being the parent or legal guardian of ______________ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

______________________________ ______________________
(parent or legal guardian) *(date)*

Highlands Chiropractic
3901 NE 4th St, Ste 109
Renton, WA 98056
Phone: 425-277-0577
Fax: 425-277-0652

Authorization to Bill Insurance

As an office COURTESY we will verify your Chiropractic and Massage Benefits as provided by your health insurance. **It is ULTIMATELY your responsibility to understand the coverage that is provided to you by your insurance company.**

There have been significant changes made to most insurance policies and we suggest you review your policy for any changes. However, we will be more than happy to answer any questions you may have in regards to your benefits.

Please check one of the following:

☐ **YES**, I request that Highlands Chiropractic bill my insurance. I understand that I am still responsible for any and all charges that accrue during my treatment there.

☐ **NO**, I do not want my insurance billed.

Patient name (print) ____

Patient signature ____

Date ____________________