

Informed Consent for Chiropractic Care & Office Policies

Office Policies

- \$25 fee for “no show” appointments without 24 hour notice.
- \$35 fee for returned check
- Payment expected at time of service including insurance co-pays.
- It is the patients responsibility to know their own insurance policy
- Patient must notify us if any personal information has changed including insurance changes, address changes, or name changes.
- Patient is responsible to get referrals if needed from their primary care.

Informed Consent For Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of disc condition, and rarely fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, and reported following my assessment.

Patient Signature (Legal Guardian)

Date

Witness Signature (Office Staff)

Date