Fitness Chiropractic Policies

Informed Consent

I hereby request and consent to the performance of (or on patient named below for which I am legally responsible) massage therapy, chiropractic and/ or acupuncture treatments & other related procedures including consultations, examination tests & diagnostic x-rays which may be recommended by doctors who now, or in the future, render treatment to me while employed by, working for, associated with or serving as replacement for my doctor.
I understand that, as with any health care procedures, there are certain complications which may arise during or after a treatment session. I do not expect the provider to be able to anticipate all risks & complications, and I wish to rely on the provider to exercise judgment during the course of the procedures which the provider feels at the time, based upon the facts then known, and are in my best interest. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.
I have had an opportunity to discuss with the provider and/or with office personnel the nature, purpose & risks of treatments & other recommended procedures & have had my questions answered to my satisfaction. I understand that the results are not guaranteed. I have weighed the risks involved in undergoing treatment & have myself 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. I intend this consent form to cover the entire course of treatment for my present condition & for any future conditions for which I seek treatment.

Authorization & Assignment

I authorize release of any relevant medical information to any insurance company, adjuster or attorney as deemed necessary to process any claims for reimbursement of charges incurred. I request & authorize direct payment of any medical insurance company benefits or any proceeds of case settlements to the treating doctor for services rendered. In the event any insurance company obligated by contractual agreement to make payment to the doctor for the charges made for your services refuses to make such payment upon demand by the office, I hereby assign & transfer to you the cause of action that exists in my favor against any such company & authorize prosecution of said action in my name to compromise, settle or resolve said claim as seen fit. I understand that I personally owe the office any amounts that are not collected from insurance company proceeds, whether it be all or part of what is due. I agree that this authorization & assignment is irrevocable until all monies owed to the office are paid in full.

Payment & Fees Agreement

I am ultimately responsible & directly liable for payment of any outstanding balances. Any co-payments, co-insurance, deductibles or other fees for any office service rendered are payable at the time of my visit. A partial payment may be required until such time that my insurance company acknowledges this claim & pays the doctor directly in full all monies due for services rendered on my behalf. A $25 fee will be charged on all my checks returned with non-sufficient funds. I agree to notify the office of any changes in my insurance policy, employer, employment status, home address & telephone numbers & attorneys involved in my case or any other accidents or injuries that I may suffer hereafter.

Privacy Confidentiality Statement

I have read & been given a copy of the office's Privacy Confidentiality Statement. By signing below, I authorize & consent to the use & disclose my protected health information as noted.

I HAVE READ AND UNDERSTAND THE ABOVE TERMS

X_____ X_____
Signature of Patient Date Date

Consent to Treatment of a Minor
I am the parent/guardian of the patient below who is of minor age. I hereby give my consent and authorize & request all procedures & treatments as stated above as deemed advisable on this minor patient.

X_____ X_____
Signature of Minor's Parent/Guardian Date