Krieser Chiropractic
Family Wellness Center

THIS DOCUMENT CONSTITUTES INFORMED CONSENT FOR CHIROPRACTIC CARE.

Chiropractic care involves the treatment and correction of the vertebral subluxation complex and its associated symptoms. Chiropractic is not a miracle cure for disease, but rather a precise and scientific approach to the correction of vertebral misalignment and nervous interference. The extent to which the patient will improve is dependant upon the body's capability to heal itself once nervous interference and incoordination has been removed. Like any healthcare procedure, there are inherent risks involved with care. These include but are not limited to local discomfort, fatigue, headache, nausea and dizziness. Though extremely rare, fracture, stroke, paralysis and/or death are also possible. When a patient seeks chiropractic care, it is essential for the doctor and the patient work together towards a common goal. This will prevent confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation complex. Our Chiropractic method of correction is by specific adjustment of the spine and/or extremities.

Vertebral Subluxations: A subluxation is the misalignment of one or more of the vertebrae in the spinal column causing alterations of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's ability to coordinate, regulate and repair itself toward maximum health potential.

If during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will so advise you. If you desire further advice, diagnosis or treatment for those findings we will recommend that you seek the services of the health care provider who specializes in that area.

I, the undersigned, have read and fully understand the above statements. 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 _____
(Signature of patient)

COMPLETE IF THE PATIENT IS A MINOR: Minor's name: _____

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

Signature: _____ *Date:* _____

Continued on Back

Privacy Policy:

At Krieser Family Chiropractic, the privacy and trust of our patients is our highest priority. Therefore, in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA), patient information will not be shared without the written consent of the patient, unless otherwise noted in Krieser Family Chiropractic's Notice of Privacy Practices. By signing below I acknowledge that I have received said notice and understand the information shared there in. If I should have any questions I know that I can contact Krieser Family Chiropractic, LLC for any questions I may have on how my private health information is being protected.

Signature: _____ *Date:* _____

☐ If you are unable to contact me I give permission to share my health, insurance, or appointment information with: _____

☐ No I do not give permission to speak with anyone other than myself

FINANCIAL POLICY:

It is the policy of Krieser Family Chiropractic that payment is due at the time at which services are rendered. Reimbursement by insurance providers or legal representatives (court settlement, attorney, etc) shall be assigned to Krieser Family Chiropractic, LLC directly. Exceptions to the aforementioned policies will be handled on an individual basis. If Krieser Family Chiropractic, LLC is required to pursue the undersigned for payment of any fees or costs, the undersigned agrees to pay all attorney fees and costs incurred in doing so.

I have read and agree to abide by the financial policies of Krieser Family Chiropractic.

*Signature:*_____ *Date:*_____

INSURANCE – Please complete if you will be using insurance:

* If you will be using insurance, a copy of your insurance card will be made and kept on file. We will call your carrier to verify coverage and benefits for you at that time.
* It is the responsibility of the patient to notify us if insurance coverage is changed or terminated. The patient is responsible for any co-pays or co-insurance.
* Any services that are not covered under the insurance benefits are the responsibility of the patient. Our office will make every effort to appeal if services are denied by carrier.
* Insurance payment is to be made directly to Krieser Family Chiropractic, LLC. In the event payment is made to patient, it is the responsibility of patient to send payment to our office.

Insured Name (if other than patient):_____D.O.B. _____

Primary Insurance: _____ Subscriber #: _____

Secondary Insurance: _____ Subscriber#:_____

I, the undersigned patient and Krieser Family Chiropractic agree to abide by these guidelines with regard to insurance payment for chiropractic services.

_____ _____

Signature of patient Date