INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND CARE

I hereby request and consent to the chiropractic services of Craig Thomas, D.C. and/or authorized persons who might now or in the future treat me while employed by Craig Thomas, D.C. in an attempt to improve my physical condition.

I understand the purpose of this and subsequent visits are to acquire chiropractic care, a natural and conservative approach to my health needs. Chiropractic care utilizes manipulation or joint adjustments, exercise, neurological reeducation, and various modes of physiotherapy.   Risks associated with chiropractic care may include, but are not limited to, muscle or ligament injuries, sprains, dislocations, fractures, disc injuries, strokes, and paralysis.

The body's nervous and musculoskeletal systems reaction to chiropractic treatments may be a generalized soreness over and around the area of my chief complaint. This is a normal and expected result because the muscles in the area have been stressed and the vertebrae misaligned. During my treatment, Dr. Craig will be releasing stress on my spine, bones, joints, and surrounding soft tissues (e.g. muscles, tendons, ligaments, bursae, and nerves). This process breaks up the pain and spasm cycle in my body, but in doing so, my body may require time to adjust to these physiological changes.

I understand that I am responsible for monitoring my own condition throughout the treatments and will inform Dr. Craig of any unusual symptoms that might occur. In signing this informed consent, I affirm that I have read the information in its entirety and that I understand the nature of the chiropractic treatment. I also affirm that all my questions regarding the chiropractic, the management of my case, and the related risks to chiropractic treatment have been answered to my satisfaction. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition for which I seek treatment.

Signature: ____ Date: ___________

PATIENT-CENTERED HOME MODEL ACKNOWLEDGMENT

In accordance to the Patient-Centered Home Model, I acknowledge that my insurance company requires my treatment plan be released to my primary care physician in order to improve communication among providers.

Primary Care Physician: __________________________________Phone:_______________

Signature: ____Date: _______________

FINANCIAL POLICY ACKNOWLEDGMENT

OVER

Discover Chiropractic is committed to providing the best treatment for patients and charging what is usual and customary for the Marquette, Michigan area.

I give permission for claims submission to my insurance company on my behalf and assign all benefit payments to Dr. Craig Thomas. I further give permission for the disclosure of my healthcare information to my insurance company for the purposes of obtaining payment for services and determining insurance benefits. Benefits quoted are an estimation of coverage, are subject to change and are not a guarantee of payment. ***I understand that I am responsible for tracking my yearly visit limit maximum as dictated by my insurance company. I am aware that some or all of the services I receive may not be covered by my insurance and I am financially responsible for any and all non-covered costs beyond reasonable and customary as defined by my insurance company.***

I agree that I am financially responsible for payment on my account in a timely manner.

I understand Discover Chiropractic is authorized to add 10% interest to my account monthly if my balance is overdue and/or my account becomes inactive. Accounts over 90 days past due will be considered for submission to a collection company and will be subject to additional fees to cover cost of that service.

I affirm that I have read and understand the information in its entirety and that all my questions regarding the financial policy and my insurance policy have been answered to my satisfaction. I intend this financial consent form to cover the entire course of treatment for my present condition and for any future condition for which I seek treatment.

Patient Name/Signature: ____ Date: ____________

Is the patient Financially Responsible for this account? *yes* *no* If no, then complete below:

Financially Responsible Party (Print): ____ Ph: ________________

Address: ____ City ______________________ St ____ Zip ________

Signature: ____ Date: ____________________

PRIVACY PRACTICES ACKNOWLEDGMENT

I affirm that I have read this form in its entirety, I understand the information and all my questions regarding the privacy policy have been answered to my satisfaction. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition for which I seek treatment. I give permission to the office to discuss insurance/financial matters with the insurance policy holder and/or person financially responsible for this account (circle one): *yes* *no*

Signature: ____ Date: ________________________

PREGNANCY RELEASE

This is to certify that to the best of my knowledge I am not pregnant and Dr. Craig has permission to perform an x-ray. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: ____

Signature: ____ Date: ___________