Account Information, Informed Consent & Privacy Policy

Account Information:

Who is responsible for this account? _____
Relationship to the patient? _____
If you wish to use your insurance, please provide insurance cards for all insurance plans you wish to be submitted at this time and read and sign the following:
Assignment and release: I, the undersigned, certify that I (or my dependent) have insurance coverage with _____and assign directly to Christensen Chiropractic Clinic, P.C. all insurance benefits, if any, otherwise payable to me for services rendered by the clinic. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the clinic to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____Date___/___/_____.
Relationship_____

Informed Consent to Chiropractic Care

Please discuss any questions or concerns with the Doctor Before signing this consent. I hereby request and consent to the performance of Chiropractic adjustments and other Chiropractic procedures, including various modes of physiotherapy, acupuncture and diagnostic x-rays by Christensen Chiropractic Clinic, P.C. I have had the opportunity to discuss with the doctor and/or other office or clinic personnel the purpose and benefits of the treatment modalities listed below. Alternatives to treatment have been reviewed.

Though Chiropractic adjustments and treatments are usually beneficial and seldom cause any problem, I understand and am informed that there are risks to treatment. Risks include, but are not limited to: fractures, disc injuries, strokes, dislocations and sprains. I understand that I may be receiving the following treatment and have the right to decline treatment at any time: **Chiropractic adjustments, Physiotherapy/Electrical therapy, Cold Laser, Acupuncture, Rehabilitation services, and Nutritional recommendations.**

I understand that Chiropractic is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

_____
Print the name of Patient/Parent/Legal Guardian/Personal Representative

_____ ___/___/_____
Signature of Patient/Parent/Legal Guardian/Personal Representative Date

Privacy Policy Written Acknowledgement

I have received or declined to receive a copy of the Christensen Chiropractic Clinic, P.C. Notice of Privacy Practices version January 24, 2019.

_____ ___/___/_____
Signature of Patient/Parent/Legal Guardian Date

__Documentation of good faith effort: Clinic Staff made every effort via mail, electronic media, or verbal communication to distribute the privacy policy to patient/parent/guardian or legal representative. Responsible party declined the information, already had received the information or received it via one of the above mentioned techniques.

Clinic Representative_____ Date___/___/_____

Version 1/24/19