



## Informed consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

**Possible Risks:** As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns, mild to severe bruising or minor complications.

**Probability of risks occurring:** The risks of complications due to chiropractic treatment have been described as “rare”, about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered “rare”.

**Other treatment options, which could be considered,** may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

**Risks of remaining untreated:** Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have read, or have had read to me, the above consent. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_



## Payment Policy

- (A) **IF YOU HAVE HEALTH INSURANCE**  
Which covers chiropractic care, we ask that you pay 100% of your first visit and 100% of all services as they are rendered until your deductible has been met. After your deductible has been met, we ask that your co-payment amount be paid as services are rendered. We will gladly process your insurance for your convenience.
- (B) **IF YOU WERE HURT ON THE JOB**  
We will bill the liable insurance company directly.
- (C) **IF YOU WERE INJURED IN AN AUTO ACCIDENT**  
We will bill the responsible insurance company or your attorney directly.
- (D) **IF YOU ARE COVERED BY MEDICARE**  
We will let you know what services Medicare typically covers, and we ask that you pay your co-pay and for any services that are not covered by Medicare at the time the services are rendered or make financial arrangements with our office staff.
- (E) **IF YOU DO NOT HAVE HEALTH INSURANCE**  
Which covers chiropractic care, we request that you pay when services are rendered or make financial arrangements with our office staff.

I authorize the doctor and staff to examine, take x-rays, treat me and do what he deems necessary in accordance with the state statutes, for the care and management of my condition. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dr. Wilhelm will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized be paid directly to ProChiropractic and this will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. All balance is due on the date of service. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I understand that a \$25.00 fee may be assessed at the Doctor's discretion for any prior scheduled appointment that I fail to attend without 24 hours advance notice to reschedule or cancel. I understand that ProChiropractic will charge interest on any past due balance at the maximum rate allowed by the law with said interest being calculated from date of default. Should I fail to pay my bill or make satisfactory payment arrangements, I agree to pay all collection costs, court costs and attorney fees incurred. I hereby authorize the release of my health evaluation, examination and treatment records, and the prognosis to my employer, my attorney or insurance company should this be necessary. **PAYMENT IS EXPECTED AT TIME OF VISIT UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE.**

I choose plan: (circle one)    A        B        C        D        E

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_