Chiropractic Treatment Informed Consent

It is important for a patient seeking chiropractic health care to understand both the objective of care and the method of treatment. After being advised of the known benefits, risks and alternatives, you have the right to be informed about the condition of your health and the recommended care and treatment so that you may make an informed decision about whether or not to undergo chiropractic care.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease. One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the vertebrae in the spinal column become misaligned and/or restricted in movement. This can cause alteration of nerve function and interference to the nervous system. There may be pain and dysfunction associated with a vertebral subluxation or it may be asymptomatic. Subluxations are corrected by an adjustment performed manually, or with a handheld instrument. An adjustment is the specific application of forces to restore movement and function to the spine at the area being adjusted. In addition chiropractic care may include ancillary procedures such as physiotherapy and other rehabilitative therapies. If during the course of care we encounter non-chiropractic or unusual findings, the Chiropractor will advise you of those findings and recommend that you seek the services of another health care provider. Chiropractors practicing at Alpenglow Chiropractic are licensed by the State of Alaska and practice within the scope of practice set forth by the Alaska State Board of Chiropractic Examiners.

All questions regarding the benefits and risks of chiropractic and the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Signature required for treatment: **PATIENT or Guardian:** _____

Date: _____ **Witness:** _____

Chiropractic Consent to evaluate and adjust a minor child: I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

_____ _____

Parent or Guardian's Printed Name Date

Signature: _____ Witness: _____

Billing Practices and Office Policies

The Client understands that:

- Services provided by Alpenglow Acupuncture, LLC are payable at the time of service.
- We accept: Cash, Visa, MasterCard, Discover Credit Cards and Personal Checks.
- Insurance is billed as a courtesy for our patients. Your co-payment is due at the time of service.
- Payment plan options are reviewed individually.

Private Insurance

Billing is a service provided to the client as a courtesy. We allow a 60-day grace period for your insurance to respond to our claims. If the insurance does not respond to our claims within 60 days, the full balance is due and payment is required. Most insurance policies do not cover herbal medicines and supplements. Our preference is ALWAYS to work with our patients directly. We reserve the right to forward any balances that remain unpaid to a collection service and you may be assessed additional fees that are in addition to your clinic charges. Should you have a question regarding a collection balance due, we will direct you to the collection service representative for resolution.

Cancellation and Missed Appointment Policy

- If you miss your appointment and do not notify the clinic, you will be billed in full for the treatment.
- If you reschedule the day of your appointment, you will be charged $50.

I have read the above and understand my financial responsibility to this organization. I also approve Alpenglow Acupuncture, LLC to charge my credit card should I fail to provide the notice required by the Appointment Policy. If I have additional questions, I will ask to speak to someone, prior to my appointment.

_____ _____

Printed Name of Patient Date

Signature: _____

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