CHIROPRACTIC CONSENT FOR CARE

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority for examination and to care for them in accordance with chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render them susceptible to injury. Even though a procedure was performed correctly, it must be understood by any patient seeking health care, no guarantee of results can be made, and that injury, paralysis or death may occur from any procedure performed, and by signing this consent for care form, I acknowledge the risk or danger and choose to have chiropractic procedures performed. The doctor, of course, will not give a chiropractic adjustment, or health care, if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service.

DIAGNOSIS

Although doctors of chiropractic are experts in chiropractic diagnosis, they are not medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition.

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of chiropractic, and traditional medicine. Chiropractic care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. A doctor of chiropractic conducts a clinical analysis for the purpose of determining whether there is evidence of Vertebral Subluxation Complexes (VSC). When such VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

RESULTS

The purpose of chiropractic services is to promote natural health through the reduction of the VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometimes the response is immediate. In other cases it is gradual. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic procedures. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions, which do not respond to chiropractic care, may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems.

TO THE PATIENT

Please discuss any questions or concerns with the doctor **before** signing this statement of consent.
I have read and understand the foregoing, and give my consent to proceed with chiropractic care.

_____ _____

DATE SIGNATURE

AUTHORIZATION AND ASSIGNMENT FOR DIRECT PAYMENT

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my health condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.

2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney, out of the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed, directly from me. I understand that whatever amounts you do not collect from insurance companies proceeds, whether it be all or part of what is due, I personally owe and agree to pay to you.

4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this State of MI.

5. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.

6. This Authorization for Assignment will be in continual effect until revoked by both parties.

_____ _____
Date Patient / Insured Signature

RECORDS RELEASE

To _____, I hereby authorize you to release to Dr. Mitchell H. Marr, D.C., any information including the diagnosis and records of treatment or examination rendered to me for all care during the period from _____ to _____.

_____ _____
Date Patient / Insured Signature

_____ _____
Date Staff Signature

RELEASE FROM CARE

I, _____ hereby understand that Dr. Mitchell H. Marr, D.C., is releasing me from care, for my _____ accident that occurred on _____, and that I have reached a pre-accident status or maximum medical improvement. I further understand that all expenses incurred from this accident are my responsibility or the insurance company's and that any healthcare expenses incurred at _____ office after the date below will be my personal responsibility. I will make financial arrangements for payment directly.

_____ _____ _____
Patient Signature Date Staff Signature