ADVANCED WELLNESS & SPORTS REHAB

We're Here for You Every Step of the Way

From the office of:
Dr. Diane K. Smith, DC, CCSP
11132 Commerce Ln N
Champlin, MN 55316
763-291-0202

Please read thoroughly, initial each section and sign at the bottom

Authorization to Release Information

X _____ I hereby authorize this healthcare entity to release all information to the care I receive to my insurance company, or third party payer or their designee. I understand that this may be necessary for the payment of my bill, determination of my benefits, or for utilization and quality review purposes.

Information about Possible risk of Chiropractic Treatment

X _____You have the right as a patient, to be informed about your condition, and the recommended treatment approach so that you may make a an informed decision whether or not to undergo the procedure knowing the potential risks involved. The statement is not meant to scare or alarm you, just to make you aware so that you may choose to, or not to undergo treatment. Doctors of Chiropractic, Medical Doctor, Osteopathic Doctors and Physical Therapists using manual therapy treatment for patients with headaches, and cervical spine (neck) pain are required to explain that there have been rare cases of injury to the vertebral artery as a result of treatment. The chance of this happening is extremely rare and estimated at about 1 per 400,00o to 1 per 10 million treatments. Appropriate testing will be performed to determine if you are susceptible to this type of injury, and you will be notified if that is the case. Should you have any questions, please discuss them with the Doctor. As with EVERY health procedure, complications may arise during treatment, these include soreness, muscle or ligament sprain or strain, dislocations, fractures, disc injury, or physiotherapy burns. Other than soreness, the others are extremely rare occurrences

Assignment of Benefits

X _____I assign all insurance benefits payable to me for my care to Advanced Wellness and Sports Rehab (the entity). I understand that this healthcare entity may be paid directly by the insurance company or other payer. This assignment will remain in effect unless revoked by me in writing. I furthermore understand that I am responsible for all charges whether or not paid by insurance. In some cases, insurance company may remit payment to me, and I in turn will pay that immediately to the entity. I hereby authorize the signature on all insurance submissions.

Guarantee of Payment

X _____I understand that guarantee payment of all charges incurred for treatment in accordance with the rates and terms of this entity, despite quotations by the insurance company to either myself or the entity. I fully understand that I am directly and fully responsible to AWSR for all medical and/or surgical benefits, including major medical, submitted by the clinic for service rendered me and that this Agreement is made solely for the Advanced Wellness and Sports Rehab 's additional protection and in consideration of the clinic's awaiting payment. I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may recover said fee.

Consent for Treatment of a Minor

For _____

I hereby authorize the entity to administer treatment, as they deem necessary to my minor son/daughter. As of this date, I have legal authority to select and authorize such care for the minor named above.

_____ (initials)

Consent for Treatment

After review of the above information, I authorize the performance of diagnostic tests, procedures and treatment deemed necessary by the personnel involved in my care.

X _____

Patient Signature or Responsible Party | Date | Relationship to Patient (if other than self)