

Life Discovery Chiropractic

Dr. Jared R. Nielsen, DC
1035 NE 6th Street, Grants Pass, OR 97526

Dr. Jon N. Chambers, DC
Ph. (541) 479-1289 Fax (541) 471-0400

INFORMED CONSENT TO CHIROPRACTIC TREATMENT AND CARE

Print Patient's Name: _____

I hereby request and consent to the performance of procedures, which are within the scope of chiropractic, including, but not limited to: chiropractic adjustments, various modes of physical therapy, nutritional therapy diagnostic x-rays on me or on the patient named above for whom I am legally responsible. I also request and consent that the procedures are to be performed by the doctor of chiropractic who currently or at any time in the future, treats me, while employed by, working or associated with or serving as back-up for the doctor of chiropractic named above. This includes those working at the clinic or office listed above or any other office, whether signatories to this form or not.

I have had an opportunity to discuss with a doctor of chiropractic named above 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 there are some risks to chiropractic treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to anticipate and explain all risks and complications; and I wish to rely on 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 be in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below, I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for future condition(s) for which I seek treatment.

Signature of Patient or Patient's Representative

Print Name of Patient or Patient's Representative

Date

Relationship or Authority of Representative

The signed original is to be filed in the patient's file

Doctor's Initials

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Disclosure of Office Fees and Policies

We would first like to take a moment to welcome you to our chiropractic office and let you know that you are very important. We are determined to let you know what condition(s) you have through thorough examination and diagnostic testing. You will be receiving the best available care. Due to the nature of care in this office, we ask that you read, understand, and sign the following disclosure of fees and payment policies.

I know that I am responsible for payment in **full** at the time of service. I understand that the initial examination fee is \$180.00. Treatment prices are based upon the scheduled time as well as any additional time spent with the doctor(s). I know that each **10-minute increment is \$40.00**. Dependent upon the specific recommendations of the doctor, other fees for services apply. Should I desire, a complete list is available at the front desk for me to see at any time. All fees are subject to change without notice.

I know that if I am **late arriving for an appointment, the doctor will see me for the remainder of my scheduled visit**. However, the **full price** of the scheduled time will be **charged**.

I acknowledge that the policy of Life Discovery is to schedule only **one person to a specific time slot**. This allows the doctors to devote their undivided attention to each individual. By honoring my time as well as the doctor's, we can obtain the maximum benefit during my treatment.

In the event of a **no-show** for any reason, I will be **charged for the full appointment time**. By signing this form, I authorize Life Discovery to fulfill this transaction.

If a 24-hour cancellation notice is given, I will not be charged for the appointment.

Any nutritional supplements that are recommended to me, I will pay for at the visit.

I fully understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that Life Discovery will prepare a Superbill and provide chart notes to assist me in making collections from the insurance company. However, I clearly understand that I am ultimately responsible for payment in full at the time of service. I agree that if any expense is incurred in the collection of any monies due on my account, this amount will also become my responsibility.

I have read, understand, and agree to the above terms.

Signature _____ Date _____

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WE BELIEVE THAT EVERY PERSON HAS THE RIGHT TO EXPECT THE VERY BEST PROFESSIONAL CARE WE CAN PROVIDE.

In turn, we expect cooperation in establishing a definite financial arrangement. Accordingly, we have established the following policies.

1. The INITIAL OFFICE VISIT IS PAYMENT IN FULL. All subsequent visits are also payment at time of service.
2. Patients involved in LITIGATION (law suits) are, as others, responsible for their services here at the clinic at the time of service.
3. Unless a patient is under CURRENT CARE in this office (within the past six months) an examination may be necessary to reinstate proper treatment. Each new injury may require an examination due to the possibility of structural changes.
4. PATIENTS ARE SEEN IN THE ORDER SCHEDULED, NOT BY WAITING ROOM SENIORITY. However, should a patient be late, others waiting will be seen in their order of appointment.
5. We reserve the right to **BILL FOR MISSED APPOINTMENTS** since time has been reserved for your health care. A **twenty-four hour notice** is required so that time can be used to schedule someone else.
6. For health considerations and due to the close interpersonal nature of the work, your **PERSONAL CLEANLINESS IS REQUIRED** for a comfortable environment.
7. **SMOKING IS PROHIBITED** because of its harmful effect on the other patients as well as the staff.
8. I grant this office permission to seek all legal means necessary to collect delinquent monies that I owe. In addition to my outstanding balance, **I will reimburse for legal and collector fees** included in this process.

Patient Name _____ Home phone _____

Street/PO Box # _____ Work phone _____

City/State & Zip Code _____ Drivers Lic # _____

Age _____ Birthdate _____ SS# _____

Occupation _____ Employer _____

Name of spouse (husband/wife) _____ Work phone _____

Spouse's occupation _____ Employer _____

By whom were you referred? _____

In the event of an emergency whom should we notify? _____ Phone # _____

Friend or relative not living with you _____ Phone # _____

MY SIGNATURE IS AN ACKNOWLEDGEMENT THAT I HAVE READ THE POLICIES ABOVE AND AGREE TO ABIDE BY THE SAME.

PATIENT SIGNATURE _____ DATE _____

The patient is a minor. Permission is hereby given by me to the doctors of this office and whomever they designate to treat the patient. I am his/her legal guardian.

GUARDIAN SIGNATURE _____ DATE _____