GILL CHIROPRACTIC
HEALTH CENTER, PA
1015 East 16th, Suite 2 Wellington, KS 67152
(620) 399-WELL
www.gillchiro.com

INSURANCE

Insured's Name_____ Date of Birth _____

Relationship to Patient_____ Phone _____

Address_____City_____State_____Zip_____

Responsible Party_____ Phone _____

Address_____City_____State_____Zip_____

ASSIGNMENT AND RELEASE

I authorize and direct payment be made directly to Chad S. Gill, D.C. of Gill Chiropractic Health Center, PA for any and all insurance benefits or reimbursement for services rendered by him which would otherwise be payable to me under any insurance or prepaid health care plan. I authorize the release of any information concerning my health and health care services to my insurance companies, pre-paid health plan or Medicare. I authorize the use of this signature on all insurance submissions.

Date_____ Signature_____

PAYMENT AGREEMENT

I understand that there is no guarantee that my insurance company or prepaid health plan will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits, or failure to pay for any reason, I understand that I am responsible for all remaining charges. Furthermore, if I do not have insurance, I understand that I am responsible for all payments at the time the service is rendered.

Date _____ Signature _____

GILL CHIROPRACTIC HEALTH CENTER

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment. I hereby give my consent to the performance of conservative noninvasive treatment of the joints and soft tissues. I understand that the procedures may consist of manipulation/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used. I also understand that x-rays may be taken to better diagnose my condition.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness: I am aware that like exercise it is common to experience muscle soreness in the first few treatments.
Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.
Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities, or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.
Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightening. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.
Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained there will be a temporary increase of pain and possible blistering. This should be reported to the doctor.

Tests will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

Treatment Results
I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

Alternative Treatments Available
Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate short-term relief, undesirable side-effects, physical or psychological dependence, and may have to be continued indefinitely. Some medication may involve serious risks.
Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bedrest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.
Surgery: Surgery may be necessary for joint stability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.
Nontreatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

Patient's Name _____Personal Representative_____ Relationship to Patient_____

Signature of Patient/Representative_____Date_____ Witness_____