A Gentle Approach Chiropractic

Take a Step Toward Better Health!

Informed Consent

I hereby acknowledge and understand that by accepting chiropractic care, there may be risks and adverse side effects with treatment (such as increased pain or swelling, exacerbation of problem, fractured vertebra, etc). I may ask for more details on side effects at any time. If I accept chiropractic care with Dr Jill Burns, I am accepting full responsibility for side effects. If I have an adverse reaction to the chiropractic care, I will discuss it with Dr Burns.

Sign _____ Date _____

Open Adjusting

It is the practice of A Gentle Approach Chiropractic to provide chiropractic care in an open adjusting environment. Open adjusting involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and remain clothed. Some ongoing routine details of care are discussed within earshot of other patients and staff.

This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations, or presenting reports of findings. These procedures are completed in a private, confidential setting.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as incidental disclosures of health information. It is our view that the kinds of matters related in an open adjusting environment are incidental matters.

Your signature indicates your authorization of this activity.

Sign _____ Date _____

Payment and Insurance

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Sign _____ Date _____