

Informed Consent

Chiropractic and Massage Therapy is a system of health care delivery and therefore we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. Our goal is to provide you with the very best care. If the results are not acceptable, we will refer you to another provider/specialist who we feel can further assist you.

Financial Information:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. 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. I will be responsible for any costs of collection, attorney's fees or court costs required to collect my bill. Upon delinquency, there will be a \$20.00 late fee assessed to my account balance. This agreement shall be governed in the state of Washington according to the laws. Venue if necessary shall take place in the city of Coeur d'Alene. A 1% interest will be calculated on overdue accounts. _____ *Initial*

I further agree that should I receive payment from any other person, entity, or insurer for any claim for injury sustained by me; I will pay in full any balance then owing to Houk Chiropractic Clinic from the proceeds of said payment. If Houk Chiropractic recovers only a portion of my balance owing pursuant to a medical lien, I agree that I am responsible for any remaining balance. _____ *Initial*

Specific Risk Possibilities Associated with Chiropractic and Massage Therapy Care.

Chiropractic and Massage Therapy, as well as many other types of health care, is associated with potential risks in the delivery of treatment. While Chiropractic and Massage treatment are remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Soreness – Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness or discomfort. _____ *Initial*

Soft Tissue Injury – Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint, ligament, tendon or another soft tissue injury. _____ *Initial*

Rib Injury – Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Treatment methods are modified and performed carefully to minimize such risks. _____ *Initial*

Physical Therapy Burns – Heat generated by physical therapy modalities may cause minor burns to the skin. These are rare, but if it occurs you should report it to your doctor, or a staff member at Houk Chiropractic Clinic. _____ *Initial*

Stroke – Stroke is the most serious possible complication of chiropractic treatment. Research studies estimate that the incidence of this type of stroke is 1 in every 1-3 million upper cervical adjustments. We work to minimize this risk through thorough evaluation of each individual patient's specific condition. Rarely though, unforeseen complications may occur. _____ *Initial*

Other problems – There are occasionally other types of side effects associated with chiropractic care. While these are rare they should be reported to your doctor promptly. *If you have any questions concerning this form or the above statements, please ask your doctor.* _____ *Initial*

Directions: _____
_____ *Initial* _____

I hereby authorize physicians and staff at Houk Chiropractic Clinic to treat my condition as deemed appropriate. The doctor will not be held responsible for any pre-existing medically diagnosed conditions. I certify that the information I provide on all forms is correct to the best of my knowledge. I also will not hold my doctor or any staff member of Houk Chiropractic Clinic responsible for any errors or omissions that I may have made in the completion of these forms.

Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered at Houk Chiropractic Clinic.

Patient Signature ***Consent for Chiropractic Treatment***

Date

Patient/ Legal Guardian Signature

Date