Keezer Chiropractic Center Inc.

3701 Colby Ave.

Everett, WA 98201

425-259-3700

Informed Consent for Chiropractic Care

Chiropractic care like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/ strain injuries, irritation of a disc condition and rarely fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care at this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and in particular your spine health. These procedures will assist us in determining if chiropractic care is needed, or if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

I hereby authorize Christopher Keezer D.C. and whomever he may designate as assistants to administer treatment as deemed necessary to my _____, _____.
Son, daughter, etc. Name of Minor

Patient Name (please print) Relationship to patient

_____ _____

Patient or Legal Guardian Signature Date

_____ _____

Witness Signature (office staff) Date

_____ _____

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Privacy Practices Consent:

I understand and do hereby consent, by my signature below, to the use and the disclosure of healthcare information for the purpose of the healthcare operations of Back Pain Relief Center. I have received a copy of Back Pain Relief Center's Notice of Privacy Practices. I have the right to request restrictions on Back Pain Relief Center's use and disclosures of the healthcare information and to revoke this consent to release information.

Print Patient Name: _____ Date: _____

Patient and/ or Guardian Signature: _____

Print name of the above signed if other than the patient: _____

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Office Financial Policies

Welcome to Back Pain Relief Center! We believe that a clear definition of our policies will allow us both to concentrate on the big issue of regaining and maintaining your health.

Appointment Policy

In order to serve all of our patients, we ask that you give 24 hours' notice should you be unable to make your appointment. When you fail to notify our office, this leaves a time slot open that could otherwise be used to see another patient in need. Please help us help others. **A $35 late fee will be assessed for all cancellations not received 24hrs before appointment date.** Thank You!

Payment Options

ANY NSF (NON-SUFFICIENT FUNDS) CHECKS RETURNED TO OUR OFFICE WITH A SERVICE FEE WILL BE PASSED ON TO THE PATIENT. OUR OFFICE DOES ACCEPT MASTERCARD AND VISA. ACCOUNTS WITH BALANCES OVER 30 DAYS WILL HAVE 1% PER MONTH ADDED TO THE BALANCE.

☐ **Plan #1** – **Insurance**: Please present your insurance card today. We will contact your insurance company to verify coverage. If you have coverage for chiropractic care our office will bill your insurance as a courtesy. After you insurance benefit has been verified, a financial payment plan will be presented to you on your following visit. Please be advised if your insurance company deems any procedure, x-ray or maintenance not medically necessary you will be financially responsible for these services.

☐**Plan #2 – Cash**: Fees are to be paid at time the services are rendered, unless special arrangements have been made in advance.

☐ **Plan #3 – Worker's Compensation:** You must report your accident to your employer and bring in the necessary insurance information. You will be required to complete and sign an accident report. You are responsible for your care should your claim be denied and payment will be required at time of service. Transfer of claims will be verified with the claims manager. Reopening of closed claims past 90 days will require patient to make personal financial arrangements and will be reimbursed if and when the claim is reopened.

☐**Plan # 4 – Personal Injury:** You must report your accident to your insurance company and present your insurance information. We will call your insurance company to verify coverage. Our office will process you claims for you. If necessary documentation is not received you will be considered a cash patient and will be required to pay at time of service.

☐**Plan #5 – Third Party Accident:** Please present accident, insurance and attorney information. We will have you sign a lien document stating you are treating with us and make the third party insurance aware that you expect them to pay for your care. We require you retain an attorney to help with your case. If the insurance company does cover all charges incurred, you will be held responsible. **Agreement with our additional Third Party financial policy required.**

Print Patient Name: _____ Date: _____

Patient and/or Guardian Signature: _____

Print name of the above signed if other than the patient: _____ _____