Move Chiropractic Consent to Care Form

I hereby give my consent to examination and the performance of chiropractic and/or acupuncture care. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissue. I further understand that my diagnosis and treatment may include the use of physiotherapy, exercises and imaging. I understand that chiropractic and acupuncture care, as with any other health profession, is associated with potential risks in the delivery of treatment. Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post-treatment soreness, disc injury aggravation, minor joint, ligament, tendon, or other soft tissue injury, minor burns to the skin while receiving moist heat, as well as rare rib injury or fracture from thoracic spine adjustments. Stroke is the most severe recorded complication of chiropractic treatment, but is also the least occurring. The estimated incidence of stroke is 1 in 3 million upper cervical adjustments (JMPT 1996: 19; 37). Precautions include pre-treatment history, examination, and x-rays prior to care minimize such risk. I hereby agree to make Dr. Amy Kempfer and/or the Staff of Move Chiropractic aware if I experience any soreness, discomfort, dizziness, headache, tiredness, nausea, vomiting, loss of balance, or any other side effects or symptoms of my treatment.

Acupuncture care also has associated risks. Most common adverse effects include dizziness, vomiting, headaches, loss of consciousness, or acupuncture needles left in the skin. Rare adverse effects include collapsed lung, bruising/ soreness at the needle site, and/or infections may occur. Organ injury may result if the needle is pushed too far, however this complication is extremely rare. I will notify the staff of any changes in needle site insertion points immediately.

The doctor may recommend supplements. Recommended supplements may reduce pain or inflammation. However, supplements are not approved by the FDA, their effectiveness has often times not been studied, and they may have adverse effects. If these effects were to occur, they should be reported to your doctor. I also understand that some supplements may interact with prescriptions or other supplements that I am taking and it is my duty to inform the staff at Body in Balance Chiropractic of all of the prescriptions and supplements I am taking now and any changes in of these in the future.

I understand that Dr. Amy Kempfer and the Staff of Move Chiropractic will rely on my personal statements of symptoms, my medical history, and other pertinent information in making the decision to recommend or perform any procedures or to define a course of treatment for my diagnosed condition. I further understand that Chiropractic is a system of health care delivery and, as with any health care delivery system, cannot make assurances or guarantee a cure for any symptom, condition, or disease as a result of treatment. If I am not satisfied or happy with the care or results provided at Move Chiropractic, Dr. Amy Kempfer will offer referral options another provider who may be able to further assist me.

General Office Policies:

Move Chiropractic will make every effort to keep my waiting time to a minimum. I agree to make every effort to arrive at my scheduled appointment(s) on time. If I find that I am unable to make an appointment, I will notify the Staff of Move Chiropractic as soon as is reasonably possible.

Financial Policy:

I authorize that direct payment be made directly to Dr. Amy Kempfer. I further understand that my insurance company may or may not cover the services rendered by Dr. Amy Kempfer and that I am responsible for any and all remaining charges. I understand that it is my responsibility to check with my insurance company about my insurance plan benefits for chiropractic care and that Move Chiropractic does not automatically check coverage information. I also agree that my balance may not exceed $300 at any time, with an exception of an authorized payment plan that I have discussed with the staff at Move Chiropractic. I understand that I will be considered to be without Insurance Coverage, and as such, agree to full payment at the time of service(s) until such time that the Staff of Moev Chiropractic has qualified and accepted my Insurance coverage.

_____ I understand that if I do not make a best effort to reschedule an appointment I miss within 4 hours of that appointment, or if I miss an appointment unannounced, my account may be charged a $25 fee that is not eligible for insurance reimbursement.

Consent To Treatment:

I consent to diagnostic studies, x-ray examinations, and any other treatment or courses of treatment relating to the diagnosis or procedures described herein. By signing this form, I acknowledge that I have read or had this form read and/or explained to me, that I fully understand its content that I have been given ample opportunity to ask questions and that any questions have been answered satisfactorily. I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic. I hereby acknowledge that I had the opportunity to ask about any potential risks and that I was informed to my satisfaction of such risks prior to the initiation and subsequent consent of my care.

Patient Name: _____

Signature of Authorized Representative: _____

Witness Signature: _____

Date: _____