Collins Chiropractic Clinic

Thank you for choosing this office to provide you with chiropractic care.

Office Policy

Appointment Policy:

Based go to upon your x-ray and exam findings. The doctor will prescribe a treatment plan. It is important that you follow the treatment plan. So you may get the maximum results in a minimum amount of time. We make every attempt to stay on schedule to avoid long waiting periods, to assist us with this, please be on time for your appointment.

Financial Policy:

Co-payments and payments for services are due on the day the service is performed. As a courtesy to you, we will file claims with your insurance company, so you can afford to bring your family and for chiropractic care. Please note file the claim does not guarantee payment from the insurance company and you remain responsible for all balances due on your account.

Informed Consent to Chiropractic Care

- I request and consent to the performance of chiropractic examination, adjustments and all other chiropractic procedures permitted by our state law, including medical records and review, various modes of physiotherapy and necessary diagnostic x-rays on my behalf (or on the patient named below, for whom I am legally responsible), by any of the treating doctor's or chiropractic on staff, and/or any license chiropractor deemed appropriate by this office.
- I understand that results of treatment are not guarantee.
- I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic, there are risks associated with treatment, although rare, including, but not limited to, fracture, disc injuries, strokes, dislocations, strains, and worsening of symptoms.
- I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at that time, based on the facts been known, is in my best interest.
- This consent form covers the entire course of treatment for my present condition, and for any future condition(s) for which I seek treatment.

Print Patient's Name: ____

Signature of Patient: ______________________________________ Date: ________________

Signature of Parent or Guardian: ____

Witness: ____ Date: _______________

HIPPA Privacy Policy

A copy of the full HIPPA Policy was made available to me by this office.

Patient's Name: ____

Signature: ____ Date: ________________

Rev. October 1, 2009