LIVINGSTON CHIROPRACTIC CLINIC

5889 Whitmore Lake Rd #3 ~ Brighton, MI 48116 ~ 810-227-7799

Confidential Patient Information and Informed Consent for Chiropractic Care

Patient Name ______________________ ______________________ ______________________
Last First Middle

Address ______________________ City, State ______________ Zip ________

Phone #s: Cell (____) ____-______ Home (____) ____-______ Work (____) ____-______

Birth Date ______________ Age ______ Gender M F Marital Status M S W D

E-mail ______________________ Soc Sec # ______________

May we send you texts or e-mail regarding your care/visits? Texts: ☐ Yes ☐ No E-mail: ☐ Yes ☐ No

Employer ______________________ Occupation ______________

Spouse's Name ______________________ Phone # (____) ____-______

May we discuss with your spouse: Your care/condition: ☐ Yes ☐ No Your account balance: ☐ Yes ☐ No

☐ Check if you would like this person, rather than your spouse, to be your primary emergency contact.

Emergency Contact ______________________ Phone (____) ____-______
(Not Spouse)

Address ______________________ City, State ______________ Zip ________

How Did You Find Us?

☐ Friend ☐ Doctor ☐ Advertisement ☐ Website ☐ Insurance ☐ Social Media ☐ Other ______________

If you were referred to us by someone, please tell us who so we can thank them. ______________

INSURANCE INFORMATION - ☐ I do not have/do not wish to use health insurance for my care.

Is your condition directly related to an auto accident? ☐ Yes ☐ No On-the-job injury? ☐ Yes ☐ No

Primary Insurance Carrier: ☐ Medicare ☐ Medicare Advantage or Plus ☐ BCBS ☐ Blue Care Network ☐ Cofinity
☐ Other ______________________
(Name of Insurance Company)

Policy/Contract # ______________________ Group # ______________

Policy Holder's Name ______________________ Birth Date ____/____/______

INFORMED CONSENT

I understand and agree that all insurance policies are an arrangement between the insurance carrier and myself. I understand billing my insurance carrier is a courtesy provided by this office and any necessary information or reports requested by the insurance carrier related to the processing of these claims by the insurance company will be provided. I understand that my insurance company may not pay for some or all of the services performed for reasons such as, but not limited to deductible and co-pay or co-insurance amounts; non-covered services; benefit maximums and limitations; or determinations of medical necessary. I, therefore, authorize this the release any information pertinent to my care to any insurance company, adjustor, or attorney involved and hereby release this Chiropractic Office and its staff of any consequence thereof. I understand that any amounts authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are finally and ultimately my responsibility 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. Further I acknowledge that I will be responsible for any cost, fees, and/or attorney fees associated with collection of amounts owed, if necessary.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me (or on the patient named above, for whom I am legally responsible) by the Chiropractor and/or anyone working in this office authorized by the Chiropractor. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the Chiropractor to exercise judgment during the course care to determine procedures and protocols that are in my best interests at the time, based upon the facts then known. I understand that I will always have an opportunity to discuss with the Chiropractor or other office personnel the nature and purpose of my care and by signing below, I consent and agree to receive Chiropractic care and treatment.

I attest that the information provided above is true and accurate to the best of my knowledge. I have read, or have had read to me, the above Informed Consent statement. I have also had an opportunity to ask questions about its contents, I intend this consent form to cover the entire course of treatment for my present condition and for any condition(s) for which I seek treatment at this Chiropractic Office in the future.

Signature ______________________ **Printed Name** ______________________

Relationship to patient if not patient ______________________ **Date** ____/____/______

Rev: 11/2019