HealthWise
Family Chiropractic, P.A.

3803 Silver Lake Road NE, Unit 100

St. Anthony, MN 55421

Certification and Assignment:

I certify that I, and/or my dependent(s), have insurance coverage with _____ insurance company and assign directly to HealthWise Family Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Doctors and staff of HeathWise may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

A copy of your insurance card and valid state ID will be taken at the time of your visit.

Please note that HealthWise Family Chiropractic has never denied anyone access to chiropractic care because their circumstances prevented them from paying our stated fees. If you find yourself in this situation, please let us know so that we can arrange an individual payment plan for you.

_____ Initial

Responsible Party:

Name of person responsible for this account (if different from patient):_____

Relationship to patient:_____

Address:_____ City:_____ State:_____ Zip:_____

Additional Therapies not Covered by Insurance:

I understand that some optional therapies (including but not limited to WellWave, Laser, or Kinesio Taping) will not be billed to my insurance plan. I understand that HealthWise will inform me when I am offered services not billed to insurance.

_____ Initial

No Show Policy:

We expect a phone call if you are unable to keep your appointment. If we do not hear from you by the time of your appointment, you will be charged a $50.00 fee for the missed appointment. Please provide us with a valid credit card. Card will not be charged unless there is a missed appointment.

Credit Card Number:_____ Expiration:____/____ CVV Code:_____

Billing Zip Code:_____ Signature:_____

Proof of Notice Provided:

I have read HealthWise Family Chiropractic's Notice of Privacy Practices, which explains how my health information may be used and disclosed, as well as, how I can get access to this information. I understand I may request a copy of this information at any time.

_____ Initial

Informed Consent for Chiropractic Treatment :

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 licensed doctors of chiropractic who now or in the future work at the clinic of HealthWise Family Chiropractic.

I understand that it is my responsibility to discuss with a doctor or other clinic personnel the nature and purpose of chiropractic adjustments and other procedures, should I have any questions. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgement during the course of the procedures which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about this consent , and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Name:_____ Signature:_____

Relationship to patient:_____