

**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 financially 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 HealthWise 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.

**Initial**

**Responsible Party**

Name of person responsible for this account Relationship to patient

Address City St

Zip

Name of employer 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. Please feel free to speak with Caela if you have any questions.

**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 fee of $50.00 for the missed appointment.

**Initial**

**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, Dr. Blomberg-Maurer, DC named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic of HealthWise Family Chiropractic.

I have had an opportunity to discuss with Dr. Blomberg, other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. 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 judgment during the course of the procedure 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 its content, 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.

**Initial**

**ADDITIONAL THERAPIES NOT COVERED BY INSURANCE**

Although I understand that some optional therapies (including but not limited to Kinesio Taping, Graston, or Laser) may be covered under my insurance plan, however I understand that because many insurance plans do not cover these services HealthWise Family Chiropractic does not bill insurance for these services. I choose to waive my right to bill insurance for these services. I instead elect to pay HealthWise Family Chiropractic’s time of service rate for these services.

**Initial**

I have fully read and understand the above policies and acknowledge each by signing below:

Patient’s Name: (please print)

Signature: Date: (signature of patient or legal guardian)

**3803 Silver Lake Road, Unit 100, St Anthony, MN 55421 | Phone: 612-789-1700 | Fax: 612-788-9011**