WALLPE CHIROPRACTIC
& WELLNESS

Consent to Examine

I give full consent to the physician to perform a diagnostic examination in order to determine health status of the musculoskeletal and nervous system. With this consent, I understand the assessment may include stressing the body to recreate and reproduce symptoms of pain in order to determine the correct diagnosis and treatment. Some forms of diagnostic examination will include regional examinations based on complaints to assess neurologic and musculoskeletal compromise, postural assessments, orthopedic tests, neurologic tests, palpation assessments, and functional squat assessments. Each examination will be based upon complaints of each patient. Each patient will be re examined as determined by the physician to track deficiencies and gains.

I understand that if I am accepted as a patient, I am authorizing the physician to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic or acupuncture treatment, will be explained to me upon my request.

I agree to pay the appropriate examination fee to Wallpe Chiropractic and Wellness for every examination performed. I also agree to pay a $50 fee for any cancelled appointments without at least 12-hrs notice or missed appointments. Some circumstances will be taken into account.

Printed Name of Patient:_____

Signature of Patient/Parent or Guardian:_____

Date:_____

Consent to Chiropractic Care

I give full consent to the physician to perform treatments in the goal of enhancing overall health based upon diagnosis from diagnostic examination. Forms of treatment include and are not limited to Chiropractic Manipulative Technique or adjustments of the spine and extremities; soft tissue therapies such as Instrument Assisted Soft Tissue Mobilization, Active and Passive Myofascial Release, Therapeutic Laser, and Rehabilitative Exercises; and Nutrition advice. I understand that any form of treatment utilized by the physician will be based upon evidence-based protocols in order to increase my healing rate, improve my functional health, and reduce symptoms of dysfunction in the body. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The physician, of course, will not give any treatment or health care if he is aware that such care may be contraindicated. Again, it is the responsibility of the patient to disclose any underlying conditions which may make certain treatments a contraindication to care. It is common for patients to feel sore following an adjustment because the body is the middle of a healing process.

I agree to pay for services rendered by either cash, check, or credit/debit. I understand that my insurance will not be accepted or billed by Wallpe Chiropractic and Wellness. I also agree to pay a $50 fee for any cancelled appointments without at least 12-hrs notice or missed appointments. Some circumstances will be taken into account.

Signature of Patient/Parent or Guardian:_____

Date:_____

WALLPE CHIROPRACTIC & WELLNESS

Consent to Acupuncture Care

I hereby request and consent to the performance of Acupuncture treatments and other forms of Oriental Medicine procedures on me (or on the patient named below for which I am legally responsible). I understand that methods or treatments may include, but are not limited to Acupuncture, Dry Needling, Chinese or Western Herbal Medicine, or Nutritional Counseling and/or supplementation. Acupuncture aims at normalizing physiologic functions, to modify the perceptions of pain, and to treat certain disease of dysfunction in the body. I have been informed that Acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that can last a few days. There have been very rare instances reported of fainting, infection, and scarring. There have been extremely rare instances reported of spontaneous miscarriage or pneumothorax. I do not expect the Physician to be able to anticipate ALL risks and complications. I wish to rely on the Physician to exercise good judgement during the course of the procedure which the he feels at the time, based on the facts then known, is in my best interest. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that may be recommended are traditionally considered safe in the practice of Chinese Medicine. I understand the same herbs may be inappropriate during pregnancy and I will inform the Physician immediately of pregnancy status for any circumstance. If I experience gastro-intestinal reactions to the herbs I will inform the Physician immediately.

I have been informed and have the right to refuse any form of treatment. I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its consent, and by signing below I agree to the above named procedures. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment. I intend this consent form to cover the entire course of my treatment for my present and any future conditions for which I seek treatment. I understand it may be necessary for the Physician to contact another one of my health care providers in order to coordinate medical treatment, to discuss any emergency situation, and/or share appropriate medical information. My signature gives the Physician permission to release my medical records for the reasons listed above unless otherwise noted.

I agree to pay for services rendered by cash, check, or credit/debit. I understand that my insurance will not be accepted or billed by Wallpe Chiropractic and Wellness. I also agree to pay a $50 fee for any cancelled appointments without at least 12-hrs notice or missed appointments. Some circumstances will be taken into account.

Printed Name of Patient:_____

Signature of Patient/Parent or Guardian:_____

Date:_____

HIPAA Consent

By signing this form, you are granting consent to Wallpe Chiropractic and Wellness to use and disclose your protected health information for the purposes of treatment and health care operations. Your health information is protected under the Health Information Protection and Accountability Act (HIPAA). This means that we cannot and will not disclose any personal health information of yours. You have a right to request a restriction of how we use and disclose your protected health information for the purposes of treatment or health care operations. We are not required by law to grant your request, but we would be bound by the agreement if the request is granted. You have the right to revoke this consent in writing, except to the extent we have already used or disclosed your protected health information in reliance on your consent. The only reason for any disclosure for health information would be upon written consent and approval of you, the patient, to designated family members or health care professionals.

Printed Name of Patient:_____

Signature of Patient/Parent or Guardian:_____

Date: _____