MONTELLESE FAMILY CHIROPRACTIC, INC.
Dr. Christopher G. Montellese, D.C.
Dr. Kristina E. Montellese, D.C.
Dr. Dustin Nagai, D.C.

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

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 by the Doctor of Chiropractic listed above and/or with other office or clinic personnel.
I further understand and am informed that, as in all health care, in the practice of Chiropractic, there are risks to treatment, including, but not limited to the following:

*While rare, some patients have experienced rib fractures or muscle and ligament sprain or strains following spinal adjustments;

*There have been reported cases of injury to vertebral artery following cervical spinal adjustments. Vertebral artery injury have been known to cause stroke, sometimes with serious neurological impairment and may on rare occasion result in serious injury. The possibility of injuries resulting from cervical spinal adjustment is extremely remote;

*There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment;

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 the time, based upon the facts then known, and is in my best interest. Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multidisciplinary studies conducted over many years and have been demonstrated to be highly effective treatment for spinal pain, headaches, and other similar symptoms. Chiropractic care contributes to your overall wellbeing.
The risk of injuries or complications from Chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my Doctor of Chiropractic the nature and purpose of Chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the Chiropractic treatment offered or recommended to me by my Chiropractor, including spinal adjustments. I intend this consent to apply to all my present and future Chiropractic care.

Date this _____ day of _____, 20___.

_____ _____

Patient's Signature (or Parent/Guardian) Witness to the Signature

_____ _____

Print Name Print Name

MONTELLESE FAMILY CHIROPRACTIC, INC.
Dr. Christopher Montellese, DC
Dr. Kristina Montellese, DC

FINANCIAL POLICY
INSURANCE, CASH, AND MEDICARE

INSURANCE

It is the policy of this office that you pay for your visit in full at the time of each visit. We will verify your health insurance coverage for chiropractic care, for you. Once your eligibility and coverage is determined we will file all insurance claims for you to the extent that your policy permits.

You are responsible for paying your deductible, co-payment and non-covered supplements, supplies, and services at the time they are rendered.

NON-INSURED

We request that you pay for all services in full at the time of each visit.

If your financial situation requires special arrangements, please speak with our Front Desk Staff.

MEDICARE

Dr. Kristina E. Montellese and Dr. Christopher G. Montellese are providers with Medicare therefore; we are required to bill Medicare for services. **Medicare does require that you pay for X-rays, examinations, supplements, supplies, physical therapy and any other non-covered services, and therefore you will be asked to pay for these services at the time you receive them.** You will also be required to pay all visits in full. Medicare will send payment directly to YOU.

IT MUST BE UNDERSTOOD:

1. This clinic DOES NOT promise that an insurance company will pay. Nor does the clinic promise that an insurance company should pay the fees as charged.
2. The clinic will not enter into a dispute with an insurance company for reimbursement or the amount of reimbursement. **This is the patient's obligation.**
3. We do file secondary insurances, other than Medicare. At the time of your visit, we will collect the copay or deductible of your primary insurance, and after your primary and secondary insurances have been processed, if there is a credit from payments, you will be reimbursed.

I authorize the release of any medical or other information necessary to process my claims. I also request payment of government benefits either to myself or to the party who accepts assignment.

Patient's Signature_____ DATE_____

Print name _____

NOTICE OF PRIVACY PRACTICES

This notice effective as of _____.

I have read the Privacy Notice and understand my rights contained in this notice.

By my way of signature, I provide Kristina E. Montellese, D.C. or Christopher G. Montellese, D.C. with my authorization and consent to disclose my protected health care information for purposes of treatment, payment and healthcare operation as described in the Privacy Notice.

_____ _____

Patient Name (Print) **Date of Birth**

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Signature