# MINOR CONSENT

## Authorization and Assignment

I authorize Lighthouse Chiropractic Health Center to release any information deemed appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me.

I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you.

I, the undersigned do hereby appoint Lighthouse Chiropractic Health Center authority necessary to endorse and cash my checks, drafts or money orders which are made payable to the undersigned or as co-payee with this clinic when said payments are due to services rendered on behalf of the undersigned by the clinic.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. I clearly understand and agree that all services rendered me are charges directly to me and that I am personally responsible 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. I understand I will be charged a 1.25% month interest fee for all accounts over 30 days past due. I will also be responsible for any costs of collection, attorney's fee or court costs required to collect my bill. There will be a $20.00 charge for returned checks. For your convenience, we accept cash, check, Visa, MasterCard, and Discover.

## Informed Consent

I hereby authorize physicians and staff of Lighthouse Chiropractic to treat my condition as deemed appropriate. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of Lighthouse Chiropractic responsible for any errors or omissions that I may have made in the completion of this form.

Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

**Specific Risk Possibilities Associated with Chiropractic Care:**

**Soreness** – Chiropractic adjustments and therapy modalities are sometimes accompanied by post treatment soreness. This is normal and acceptable accompanying response to chiropractic care and therapy modalities. While it is not generally dangerous, please advise your doctor if you experience soreness and discomfort.

**Soft Tissue Injury** - Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint ligament, tendon, or other soft tissue injury.

**Rib Injury** – Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

**Therapy Burn** – Heat generated by Therapy modalities may cause minor burns to the skin. This is rare, but if it occurs, you should report it to your doctor or a staff member.

**Stroke** – Stroke is the most serious complication of chiropractic treatment. The most recent studies estimate that the incidence of this type of stroke is 1 in every 5 million upper cervical adjustments.

**Other Problems** – There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

If you have any questions concerning this form or the above statements, please ask your doctor.

*Having carefully read the above Authorization and Assignment and Informed Consent, I hereby give my consent to have chiropractic treatment administered and authorize the assignment of payments. I clearly understand that all services rendered to me are charged directly to me and that I am personally responsible for payment.*

**Patient Name: _____ Relationship to Patient: _____**

**Please Print Name of Parent, Guardian, or Personal Representative _____**

**Parent, Guardian or Personal Representative's Signature _____ Date: _____**