Wieging Physical Medicine, LLC

Acct: _____

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this, we believe communication is the key Please read below and if you have any questions, feel free to ask a member of our clinic staff.

INFORMED CONSENT FOR TREATMENT

A patient, in coming to Wieging Physical Medicine, LLC, gives the doctor(s) permission & authority to care for the patient in accordance with chiropractic tests, diagnosis and analysis. The chiropractic adjustments or other clinical procedures offered in our clinic are usually beneficial & seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor(s), of course, will not give any treatment or health care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures, whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Doctor of Chiropractic (DC) or any other practitioner in our clinic. Doctors of Chiropractic provide a specialized, non-duplicating health care service. Your DC is licensed in a special practice and is available to work with other types of providers in your health care regime. We also employ Physician Assistants, Chiropractic Assistants & Nurse Practitioners. I understand that if I am accepted as a patient at Wieging Physical Medicine, LLC, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, physical therapy or any other treatment will be explained to me upon my request. Our clinic has a common therapy area & open reception area, where people can overhear conversations. Some of your care maybe provided in these areas, but private consulting areas are available upon request.

Patient Signature:_____ Date:_____

Women only:

To the best of my knowledge **I am/ am NOT pregnant and give/ don't give** permission to x-ray me for diagnostic purposes.

Missed Appointment Fee

Any Massage appointment that is not canceled 24 hours prior to schedule appointment will be subject to a charge of $20

Consent to Evaluate and Treat a Minor:

I, _____being the parent or legal guardian of _____, have read and fully understand the terms of acceptance and hereby grant permission for my child to receive treatment in our clinic.

Communications:

If you wish to allow our office staff to speak to someone other than you regarding your treatment and/or financial information, we ask that you list that person(s) below.

Name: _____ Relationship: _____

Appointment Reminder Calls/Text Messaging:

Our office utilizes automated appointment reminder calls and text messaging. Please select your preference:
Phone call: _____ Text Message:_____ No Reminder:_____

As a courtesy, our office may provide reminder calls, which only disclose the date and time of your next appointment. This information may be left on your answering machine or voicemail. You agree, in order for us to provide services to you and/or collect payment, in addition to regular mail, we may contact you by telephone, at any telephone number associated with your account, or by any email address associated with your account. Method of contact may include pre-recorded and/or the used of an automated dialing device.

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request, I will be given a copy.

Print Name:_____ Signature:_____ Date:_____