

# Cornerstone Chiropractic

Dr. Cameron Lichfield  
2003 132<sup>nd</sup> Street SE, Suite E, Everett, WA 98208  
(425) 379-6301

## Terms of Acceptance ♦ Informed Consent for Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

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Print Name

Signature

Date

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### Consent to treat a Minor

I, \_\_\_\_\_, being the parent or legal guardian of \_\_\_\_\_ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic evaluation (including X-ray examination) and care or massage therapy.

Signature \_\_\_\_\_

Date \_\_\_\_\_

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### Pregnancy Release (all female patients age 10 and older)

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual period: \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

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## **BILLING INFORMATION:**

Name of person responsible for this account \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Will we be billing your health insurance?  Yes  No

## **HEALTH INSURANCE**

Health Insurance Co. Name: \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Policy Holder's address (if different than patient's) \_\_\_\_\_ Employer: \_\_\_\_\_

Policy Holder's Date of Birth \_\_\_\_\_ Policy Holder's Social Security Number \_\_\_\_\_

*If you have Secondary Insurance coverage, please let the front desk know.*

## **AUTO ACCIDENT**

Will we be billing your Personal Injury Protection (PIP)?  Yes  No

Your Auto Insurance Company \_\_\_\_\_ Phone # \_\_\_\_\_

Insurance Address \_\_\_\_\_

Claim Number \_\_\_\_\_ Adjuster's Name \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Policy Holder's address (if different than patient's) \_\_\_\_\_

Policy Holder's Date of Birth \_\_\_\_\_ Policy Holder's Social Security Number \_\_\_\_\_

Insurance of At-fault party (if other than above) \_\_\_\_\_ Phone # \_\_\_\_\_

Claim Number \_\_\_\_\_ Adjuster's Name \_\_\_\_\_

Insurance Address \_\_\_\_\_

## **L&I/WORK INJURY**

Claim Number \_\_\_\_\_ Date of Injury \_\_\_\_\_

Claims Adjuster \_\_\_\_\_ Adjuster's phone number \_\_\_\_\_

Is your claim through L&I or a Self Insured company? \_\_\_\_\_

Address of Self Insured company (if applicable) \_\_\_\_\_

Has your claim been opened by another health care provider? \_\_\_\_\_

**Insurance Billing Policy: If you have coverage for chiropractic care or massage therapy, our office will bill your insurance company as a courtesy to you. You will be responsible for your deductible, co-payment or co-insurance at the time services are rendered. Please remember, services are rendered to you, the patient, and not to the insurance company. You are ultimately responsible for your bill, REGARDLESS OF INSURANCE PAYMENT.**

**AUTHORIZATION:** I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Cornerstone Chiropractic, Dr. Cameron S. Lichfield to release any information including the diagnosis and records of any treatment or examination rendered to me, or my child, during the period of such chiropractic care or massage therapy to third party payers. I authorize and request my insurance company to pay directly to Cornerstone Chiropractic Inc, PS, Dr. Cameron S. Lichfield insurance benefits otherwise payable to me. I fully understand that I am directly and fully responsible to said doctor or his/her office for all health care bills submitted by them for services rendered me regardless of payment by applicable insurance company/companies.

Signature \_\_\_\_\_ Date \_\_\_\_\_