

ELAN VITAL MEDICAL CENTER

DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC HEALTHCARE

INFORMED CONSENT

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare the necessary reports and forms to assist me in making collections from the insurance company and that I hereby authorize and assign all benefits so that all bills are paid directly to the Doctor's Office to be credited to my account. However I clearly understand and agree that all services rendered me are charged 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 hereby authorize the Doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic Health Care and I give authority for these procedures to be performed. I understand and agree that a Doctor of Chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and/or VSC complexes are found, Chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the Chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body and opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

I also agree that I am responsible for all bills incurred at the office and assign all insurance benefits to this office.

I have read and understand the foregoing.

NAME: _____

SIGNATURE: _____ DATE: _____

WITNESS: _____