LEVIN & CHELLEN CHIROPRACTIC

4144 County Road 101, Minnetonka, MN 55345-1727
(952) 474-1777

SHARON R. LEVIN, DC
Doctor of Chiropractic

NELS H. CHELLEN, DC
Doctor of Chiropractic

Name _____ **Phone (____)** _____ **Cell Phone (____)** _____

Address _____ **E-mail*** _____

City _____ **State** _____ **Zip Code** _____

Birth Date _____ **Age** _____ **Gender: Female Male**

Place of Work _____ **Work Phone** _____

Spouse's Name _____ **Spouse's Occupation** _____

Who to contact in case of emergency _____

Their phone _____ **Relationship to you** _____

How will your bill be paid? (circle one or more) Cash Credit Card Accident Insurance Health Insurance

Person responsible for your account _____

Are you a student? (circle) Yes No Full time Part time

How did you hear about us? referral:_____ **advertisement public event web site other:**_____

IT IS ESSENTIAL THAT WE MAINTAIN A FRAGRANCE-FREE ENVIRONMENT IN OUR CLINIC. PLEASE REFRAIN FROM WEARING PERFUME, COLOGNE, AFTERSHAVE, PERFUMED LOTIONS OR BODY OILS ON YOUR VISIT TO OUR OFFICE. MANY PEOPLE HAVE ALLERGIES OR SENSITIVITIES TO THESE SUBSTANCES. THANK YOU.

Unless I am using BlueCross BlueShield, automobile accident insurance, workers' compensation insurance, or a slip and fall claim, I agree to pay all fees by cash, check, or credit card at the time services are rendered, unless other arrangements are made. If any other type of insurance claim is going to be filed, I agree to pay all charges at the time of service and then submit the claim myself for which any reimbursement will be made directly to me from the insurance company. Levin and Chellen Chiropractic will provide the information necessary to complete the forms as well as provide additional assistance as required. There will be a charge of $30.00 for a returned check.

_____ _____

Signature **Date**

***Please give us your e-mail address if you wish to be sent notices from our clinic such as vacation periods, wellness workshop dates, and periodic health tips. Your e-mail address will not be shared with any other organization.**

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Chiropractic Informed Consent

Dear Patient,

Every type of health care is associated with some risk of potential problem. This includes chiropractic health care. We wish you to be informed about the possibility of any potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

Consent to Treatment

I understand the following points, and have asked for explanations otherwise, to my satisfaction and I have had the opportunity to discuss them with the doctor and/or other clinic personnel.

1. I understand that the chiropractor will use his/her hands or a mechanical device upon my body to adjust a joint, and there may be an audible “pop” or “click” as a result of joint movement.
2. In addition to adjustments, therapies such as infrasound and manual muscle therapy and/or massage therapy may be part of my treatment. Home exercises and stretching may also be suggested.
3. The practice of health care is not an exact science, but relies upon information related by the patient, information gathered during the examination (and the doctor’s interpretation thereof), as well as the doctor’s judgment and expertise. Chiropractic health care is no different.
4. It is not reasonable to expect my doctor to be able to anticipate or explain all possible risks and complications of a given procedure on any particular visit, and I wish to rely on the doctor to exercise professional judgment during the course of any procedures which s/he feels at the time to be in my best interest.
5. Though infrequent, as with any health procedure, there are certain complications which may arise during chiropractic health care. These complications include soreness, sprains/strains, dislocations, fractures, disc injuries, cerebral-vascular accidents, physiotherapy burns, or soft tissue injuries. Except for soreness, these complications are extremely rare occurrences.
6. Chiropractic is a system of health care delivery; therefore, as with any other health care delivery system, we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will give you our best care.
7. I understand that there are other forms of treatment, including drugs and surgery, which could be treatment options for my condition, but at this time, I choose chiropractic care.

I have read the above consent, or it has been read to me, have had the opportunity to ask questions and receive answers, am comfortable with the information provided, and consent to chiropractic treatment and management on that basis. In signing this document, I in no way compromise my protection against negligence.

_____
Patient Name Printed

_____ _____
Patient Signature **Date**

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CANCELLATION & LATE ARRIVAL POLICY

We require a 24 hour notice of cancellation for a scheduled appointment. You will be responsible for the current office visit fee for the missed appointment if this notice is not given. Other people may need care and be unable to receive it during the time you reserved. If your care is being paid for by insurance, please note that insurance carriers will not pay for missed appointments, therefore payment will be your responsibility.

Also, please adhere to your scheduled time for service. Your prompt arrival ensures that you will receive your full alloted time for treatment. If you arrive later than 10 minutes past your appointment time, we will not be able to treat you due to time constraints. You will then be charged the missed appointment fee.

Your considerate observance of this policy helps make it possible for us to serve you and others who need our care. Thank you for your cooperation.

I, (print your name) _____ have read and agree to abide by this policy.

Signature: _____ **Date:** _____

MESSAGE WAIVER

I authorize Levin and Chellen Chiropractic to leave messages verifying, or otherwise pertaining to, my appointments at my home, cell phone, or place of employment.

Signature: _____ **Date:** _____

ASSIGNMENT and RELEASE

I hereby release my insurance benefits to be paid directly to Levin and Chellen Chiropractic and acknowledge that I am financially responsible for all fees. I hereby authorize Levin and Chellen Chiropractic to release any of my health care information required to support my claim.

Signature: _____ **Date:** _____

AUTHORIZATION for PROFESSIONAL COMMUNICATION

I authorize the doctors of Levin and Chellen Chiropractic to share information regarding my case with the appropriate health professional to whom I may be referred, for the purpose of optimal case management.

Signature: _____ **Date:** _____