INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-ray(s) and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for or associated with, or serving as back-up for the doctor of chiropractic named below.

I understand that, as with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include but are not limited to; fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgement during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, are in my best interest.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read ( ) or have had read to me ( ) the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name(s) and Address(es) of Office or Clinic	Print Name(s) of Doctor(s) Treating This Patient
LAKEWOOD CHIROPRACTIC CLINIC	DR. FARID SAMADZADA D.C., M.D.
6336 GASTON AVENUE	
DALLAS, TX 75214	

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

Printed Name of Patient

Signature of Patient — Date

Signature of Patient's Representative (If minor or physically incapacitated) — Date

Witness to Patient's Signature — Date

Translated By — Date

Reorder H.J. Ross Co. (800) 562-3306

Form I-113

LAKEWOOD CHIROPRACTIC CLINIC POLICY

OUR OFFICE IS PLEASED TO ACCEPT YOUR INSURANCE ASSIGNMENT, AS SOON AS YOUR EXACT COVERAGE IS VERIFIED BY THE RESPONSIBLE PARTY. WE WILL FILE YOUR CLAIM FORMS AND ASSIST YOU IN EVERY WAY WE CAN. MOST PEOPLE TODAY HAVE HEALTH INSURANCE AND MOST POLICIES COVER CHIROPRACTIC CARE, BUT BENEFITS AND LIMITATIONS VARY WIDELY. IF YOUR POLICY PROVIDES TYPICAL CHIROPRACTIC COVERAGE AND BENEFITS, WE WILL ACCEPT ASSIGNMENT ON YOUR INSURANCE COMPANYS POLICY, WITHIN THE FOLLOWING PROVISIONS AND LIMITATIONS:

1. THE PATIENT'S INSURANCE POLICIES AND BENEFITS MUST BE REVIEWED AND FOUND TO BE ACCEPTABLE TO US.

2. THE PATIENT MUST SIGN OUR PROVIDER/PATIENT AGREEMENT. PROVIDER/ PATIENT AGREEMENT MUS BE HONORED BY THE INSURANCE COMPANIES.

3. PATIENT SHOULD UNDERSTAND THAT THEY ARE RESPONSIBLE FOR CO-PAYMENT AND DEDUCTIBLES ACCORDING TO THEIR INSURANCE POLICY. ***_____(INITIAL)

4. OUR OFFICE DOES NOT GUARANTEE THAT YOUR INSURANCE WILL PAY. WE WILL MAKE EVERY ATTEMPT AT THE BEGINNING OF YOUR HEALTH CARE, TO RECEIVE VERIFICATION OF YOUR POLICY AND WHAT IT COVERS. HOWEVER, IF FOR SOME REASON, YOUR INSURANCE CLAIM IS DENIED, YOU ARE RESPONSIBLE FOR THE FULL AMOUNT OF YOUR BILL.

5. OUR OFFICE WILL NOT ENTER INTO A DISPUTE WITH YOUR INSURANCE COMPANY OVER YOUR CLAIM. THIS IS YOUR RESPONSIBILITY AND OBLIGATION.

6. SINCE BY TAKING YOUR INSURANCE ON ASSIGNMENT, WE HAVE TO WAIT FOR PAYMENT, THIS COURTESY MAY BE WITHDRAWN AT ANY TIME IF CIRCUMSTANCES WARRANT.

7. WE WILL BE HAPPY TO COMPLETE DISABILITY FORMS, ATTORNEY FORMS, AND VARIOUS OTHER FORMS FOR YOU HOWEVER YOU SHOULD UNDERSTAND THAT THERE WILL BE A TWO DAY WAITING PERIOD FOR COMPLETION.

8. MATERIAL ITEMS, SUCH AS VITAMINS AND APPLIANCES ARE NOT INCLUDED IN THIS PROGRAM AND MUST BE PAID FOR BY THE PATIENT.

9. WE ARE A MEDICARE PROVIDER. MEDICARE PATIENTS ARE ONLY REQUIRED TO MEET MEDICARES DEDUCTIBLE, PAY FOR X-RAYS REQUIRED BY MEDICARE BUT NOT COVERED BY MEDICARE, AND PAY FOR REQUIRED ADDITIONAL THERAPIES NOT ALLOWED BY MEDICARE. VITAMINS AND ICE PACKS ARE NOT COVERED BY MEDICARE AND ARE PATIENT'S RESPONSIBILITY.
****_____(INITIAL)

10. IT IS OUR OFFICE POLICY TO MAKE CERTAIN THAT WE PROVIDE THE FREE SERVICES PRIOR TO PROVIDING ANY NON-FREE SERVICE AND THE PATIENT AGREES THAT THEY HAVE NOT BEEN COERCED IN ANY WAY TO PROCEED WITH ADDITIONAL NON-FREE SERVICES FOR WHICH FEES WILL BE CHARGED.

11. WE WOULD REQUEST THAT ALL CHILDREN BE ACCOMPNIED BY AN ADULT AND REMAIN IN THE WAITING ROOM WHILE YOU ARE IN THERAPY.

12. IF YOU UNDERSTAND AND AGREE WITH ALL OF THE ABOVE OFFICE POLICIES, PLEASE SIGN YOUR NAME.

_____
PATIENT'S SIGNATURE (PARENT OR LEGAL GARDIAN, IF MINOR).

IN CASE OF EMERGENCY, PLEASE
NOTIFY_____ PHONE NUMBER_____

RELATIONSHIP_____ ADDRESS_____ DATE_____