

Fortin Health & Wellness Clinic, P.A.

Informed Consent

I am consenting to have Dr. Brenda Fortin, DC treat me with chiropractic or/and acupuncture treatments as medically necessary. I understand that under Minnesota Law, In order for me to receive acupuncture, I must also be adjusted at that same visit.

Every type of health care is associated with some risk of potential problems. We are informing you of some possible problems associated with chiropractic health care before treating you.

1. The chiropractor will use 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. The practice of health care is not an exact science, but relies upon information related by the patient, information gathered during the examination, doctor's interpretation of the information, as well as the doctor's judgments and expertise. Chiropractic care is no different.
3. 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 she thinks at the time to be in my best interest.
4. Though infrequent, as with health care procedures, there are certain complications which may arise during chiropractic health care. These complications include soreness, sprain and strains, dislocations, fractures, disc injuries, cerebral-vascular accidents (strokes), physiotherapy burns, and soft tissue injuries. There are also certain complications with acupuncture which are also infrequent, like bruises, bleeding from the point that was needled and lung punctures. These complications are extremely rare occurrences.
5. As with any health care delivery system, we cannot promise a cure for any symptom, disease or condition as a result of treatment in the clinic. We will give you our best care.
6. There are other forms of treatments, including drugs and surgery, which could be a treatment options for my condition. At this time I choose chiropractic care.

I Have Read the Informed Consent and Had the Opportunity to Ask Questions

Print Name _____

Signature _____ Date _____

Patient Representative (If patient is a minor or patient is unable to sign)

Signature _____ Date _____

Relationship to Patient _____

Fortin Health & Wellness Clinic, P.A.

Authorization to Bill Insurance

I request that payments from my insurance company, third party or other health service plans are made directly to Fortin Health & Wellness Clinic. I authorize Fortin Health & Wellness Clinic, P.A. to release all health information about me to my insurance company, third party, other health service plans and Physicians Resource Network, who is a billing service hired by Fortin Health & Wellness Clinic, PA, made for the purpose of billing, payment of insurance claims and fraud investigations.

I also agree to pay for services provided by Fortin Health & Wellness Clinic, P.A. that were not paid for by my insurance company, third party or other health service plans. I will pay within twenty days from the date of each monthly billing statement my total balance. **There will be no finance charges for first 60 days on unpaid balances. Unpaid balances greater than 60 days will receive a finance charge of \$5 every 30 days. Patient may at any time pay the full amount plus any finance charges.**

All unpaid balances of 180 days will be sent to our collection agency including but not limited to collection fees, billing and mailing fees, service fees, attorney fees and legal fees. I agree to pay Fortin Health & Wellness Clinic, P.A. for all costs incurred to collect payments including but not limited to legal costs such as attorney fees, cost and fees for billing and mailings, service fees and collection service fees. I release my information and services rendered to me to accomplish the collection of my balance owed to Fortin Health & Wellness Clinic, PA.

I Have Read the Authorization Form and Agree

Signature _____ Date _____

Print _____

Patient Representative (If patient is a minor or unable to sign)

Signature _____ Date _____

Relationship to Patient _____