Got Your Back Lifestyle Chiropractic
- EXPLANATION OF PROFESSIONAL FEES
- FINANCIAL POLICY
- INFORMED CONSENT FOR CHIROPRACTIC CARE

EXPLANATION OF PROFESSIONAL FEES

New Patient History & Examination: $200.00
A case history involves questions regarding your past and present health complaints. Dr. Smith will perform a complete chiropractic evaluation of your spine and extremity function. Dr. Smith will also perform range-of-motion tests, postural analysis, orthopedic/neurological tests that are required for your condition.

Established Patient Re-Examination: $125.00
If you have been out of care (not adjusted) for a 6 month period a re-exam will be performed to assess your current condition.

Chiropractic X-Rays or Advanced MRI/CT Imaging:
Subsequent to the consultation and exam, and after careful review of your complaints, Dr. Smith will determine if X-Rays or advanced imaging is necessary for you proper care. You will be referred out to a radiology center where the appropriate imaging can be performed.

Chiropractic Adjustment:
$75.00 spinal adjustments, $35.00 extremity, cranial, TMJ or organ work
$65.00 complete nutrition/food testing evaluation using muscle response testing

PACKAGES:

10 pack of adjustments	$650	($65 /adjustment)
5 pack of adjustments	$350	($70 /adjustment)

**If you intend to submit to insurance you are not eligible to package pricing.*

The chiropractic adjustment is the application of a specific directional thrust to a region or regions of the spine with the specific intent of correcting subluxations in the spinal segments. The chiropractic adjustment is made only after careful analysis and is delivered in a specific manner to achieve a pre-determined goal. It is a precise, delicate maneuver, requiring special bioengineering skills and deftness.

Extremity, cranial and TMJ adjustments help to restore normal motion patterns in the effected joints or cranial bones.

Organ work, called CMRT (Chiropractic Manipulative Reflex Technique) helps to balance organ function.

FINANCIAL POLICY

We are a "Time of Service" business which means that your payment is due at the time your services are rendered. We do not accept insurance. Since your insurance policy is a contract between you and your insurance company, you are responsible for the cost of services you receive from Got Your Back Lifestyle Chiropractic. If you would like to submit your receipts to your insurance company for reimbursement, we will be happy to provide you with a super bill.

MISSED AND LATE APPOINTMENTS

Your appointment time is reserved for you. If you are unable to keep the appointment we request that you call our office at least one working day in advance to avoid a charge.

If you are more than fifteen minutes late for your appointment we will make an attempt to accommodate you during that time. You may be asked to wait or we may have to reschedule you for another time.

We have a voice mail system in place that allows you to leave a message 24 hours a day for any appointment that must be canceled after normal business hours.

When appointments are missed or canceled at the last minute some other patient is deprived of the opportunity to see the doctor during that time.

INFORMED CONSENT FOR CHIROPRACTIC CARE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working toward the same objective. It is important that each patient understand both the objective and the method that will be used to attain this objective. 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 effect 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 vertebra 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.

_____	_____	_____
Print Name	Signature	Date

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

_____	_____
Guardian/Parent Signature	Date

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her 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 cycle: _____

_____	_____	_____
Print Name	Signature	Date