Gaslight
FAMILY CHIROPRACTIC

2213 Wealthy Street SE, Ste 220
Grand Rapids, MI 49506
P: 616.458.2348
GaslightChiro.com

First Name MI Last Name Date of Birth

Address City State Zip Code

Cell Phone Email

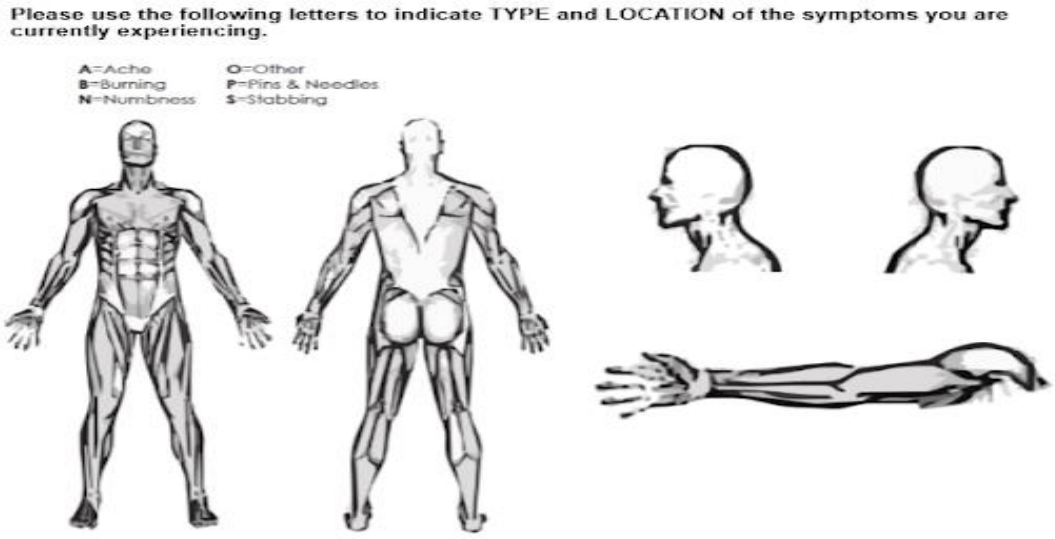
Reason for seeking care:

Are you currently taking medication? ____No ___Yes Medications: _____
Do you have any allergies? If yes, please list:

Is there a chance that you are pregnant? ____ No ____ Yes
How did you hear about our office? _____ Referral Pt. Name:_____

Please use the following letters to indicate TYPE and LOCATION of the symptoms you are currently experiencing.

A=Ache O=Other
B=Burning P=Pins & Needles
N=Numbness S=Stabbing



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Informed Consent for Therapeutic Massage

I understand the general benefits of massage, possible massage contraindications and treatment procedure have been (or will be) explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my primary physician for any condition that I may have. I am aware that massage scheduled infrequently has limited benefits, and it is recommended to receive massage at least (1) session every four to six (4-6) weeks for full benefits.

I understand that the massage therapist does not diagnose any illness or disease, does not prescribe any medications and that anything said before, during, or after the session should not be inferred as such. I understand that it is MY responsibility to communicate and give feedback regarding any pain or discomfort I may experience during the session.

I have informed (or will inform) the massage therapist of all my known physical and medical conditions, as well as my current medications. I will keep my massage therapist up-to-date on any medication or health changes. I understand that withholding medical information could be harmful to myself, and that withholding this information removes the massage therapist from any liability.

I understand that therapeutic massage is non-sexual in nature and if the massage therapist feels threatened or harassed in any way, the session will end immediately, full payment will be made, and no future appointments will be available to me.

By signing below, I acknowledge that I have read and understand the above statements, and therefore am giving my consent for this and every therapeutic massage session at Gaslight Family Chiropractic.

_____

Patient Signature Patient Printed Name Date

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Financial & Cancellation Policies Payments

Our clinic has established a single fee schedule that applies to all patients for each service provided. *Patients who meet state and/or federal poverty guidelines or other special circumstances outlined in our "Hardship Policy" may be offered a discount for a period of time as determined by the clinic.

Please read the following and initial your preference for the method of payment on you account at this clinic. Please notify this office if the status of your insurance changes.

Private Pay: Please select either option 'A' or option 'B' on our Policy Agreement form if you are choosing to pay your account personally.
A:_____ I agree to assume all responsibility for my account, and to keep said account current by paying for services as they are rendered.
B: _____ I have insurance, but I wish to file my claims personally, and I agree to assume all responsibility for my account. I understand it is my responsibility to keep my account up-to-date by paying for each visit at the time services are rendered. (I will need a Health Claims Form)

Insurance Coverage

We are in-network with **Blue Cross Blue Shield** and are able to bill your services to them directly.

Your insurance policy is an agreement between you and your insurer, not between your insurer and this clinic. We bill services to insurance as a convenience to you. Like all types of care, coverage for chiropractic and therapeutic massage services vary between insurers and plans. Most insurance policies require the beneficiary to pay co-insurance (a percentage of the service fees), co-payment (co-pay - a flat fee per visit) and/or a deductible. We are not responsible for your insurer's final payment and benefit determinations. You may be entitled to a network or contractual discount if we are a participating provider in your health plan.
C: _____ Please initial here if you have BCBS and would like us to bill services on your behalf.

Cancellation Policy

We know that your time is valuable and will make sure to notify you as soon as possible if there is a conflict in our ability to keep your appointment as scheduled. We ask that you honor our time as well with at least 24-hour notice if you need to reschedule an appointment. **A $45.00 fee will be charged in the case of a missed visit without advanced notice.** We understand that life happens and in the case of emergency or unavoidable circumstances we will waive the fee.

_____ My initials here indicate that I have read and understand the above Cancellation Policy. I understand that all health services rendered to me and charged to my account are my personal financial responsibility and I agree to adhere to the aforementioned conditions of these financial and cancellation policies

Patient Signature Patient Printed Name Date