CONSENT FOR TREATMENT AND FEE STRUCTURE

FEE STRUCTURE

EXAMINATION	
CONSULTATION	
POSTURE ANALYSIS	
SCANS (SEMG, HRV, THERMAL)	
SPINAL EXAM	
REPORT OF FINDINGS	
TOTAL	**$130**
RADIOLOGY	$45 / view
ADJUSTMENT	$75

FEES: I understand the above fees and give my consent to paying the amounts listed respective to the treatment I have received. I also consent to allowing the Doctor to recommend any X-Rays he/she deems necessary to better understand my condition and monitor my progress.

Patient Initials: _____

OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference of the expression of the body's innate wisdom. Our main method is specific adjusting to correct vertebral subluxations.

PROBLEM: VERTIBRAL SUBLUXATION - A misalignment of one or more of the 24 vertebrae in the spinal column, which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

TREATMENT: ADJUSTMENT - Our chiropractic method of adjusting is by specific applications of forces to the spine in order to facilitate correction of vertebral subluxation. Though uncommon, there are potential risks of chiropractic care such as the rare cases of sprain/strain injuries, irritation of a disc condition, and although rare, minor stress fractures.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings - we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the service of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others.

I understand the objective and method of treatment at Hill Family Chiropractic, as well as the potential risks of adjustments. After careful consideration, I consent to allow the doctors of this practice to administer manual adjustments of vertebral subluxations, as they deem necessary, to correct my particular condition at any time throughout the entire clinical course.

_____ ____/____/____

Print Patient Name DOB

_____ ____/____/____

Patient or Authorized Person's Signature Date