Healing Horizons

Integrated Health Solutions

Welcome to Healing Horizons Integrated Health Solutions

CHIROPRACTIC CARE CONSENT

Thank you for choosing Healing Horizons. We look forward to providing quality healthcare in order to assist you in achieving your health-related goals. In order to serve you as efficiently as possible, please answer all of the following questions and read and sign all forms. All information will be held in the strictest of confidence.

Name_____ Age_____ DOB_____ M F Marital Status_____ Phone_____

Address_____City/State_____Zip_____

Cell_____ If we may send you information, please provide your email_____

Occupation_____ Emergency Contact_____ Relation_____ Phone_____

Who referred you to Healing Horizons? _____ May we thank him/her? Y N

*I voluntarily request and consent to be treated by Michael Hawthorne, DC, for the performance of chiropractic procedures, including various modes of physiotherapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible).

*I understand and I am informed that, as is with all healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

*I understand that Chiropractic adjustments and supportive treatments are designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure.

*I understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery.

*I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

*At times you may wish to contact Healing Horizons via email, or vice versa, for communication which may contain protected health information. ***Please initial for consent***_____

*I understand that the following providers will be present at Healing Horizons collaborative care meetings in which my care may be discussed: *April Schulte-Barclay,* DAOM, LAc; *Joseph Ellerin,* LAc, LMT, Dip. Hom, CST; *Paula King,* PhD; *Melissa Chambers,* LMT; *Meghan Rickman,* LMT; *Kathleen Threet,* LMT; *Joe Heinecke,* DC; *Michael Hawthorne*, DC; *Gloria Palefsky*, CINHC. I also understand that other methods of collaboration, such as confidential email and private electronic group communication, may be used to coordinate my care in accordance with HIPAA regulations.

Please initial for consent_____

I understand payment is due at the time of service and I agree to address any financial concerns with Healing Horizons prior to treatment. I understand that Healing Horizons gladly accepts cancellations up to 24 hours in advance without penalty. Missed appointments without advance notice will be charged 50% of the scheduled treatment. Please initial_____

I have carefully read and I understand all of the above information. I appreciate that it is not possible to consider every possible complication to care. I am fully aware of what I am signing.

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Signature (Patient/Parent/Guardian) Date Rev 6/1/2020