Vail Chiropractic Clinic P.L.L.C.
164 E. 4th street
Winona, MN 55987
(507) 474-4260

Payment and Insurance Pt. Initials:

I understand and agree that the health and accident insurance policies are an arrangement between the insurance carrier and myself. This office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

CONSENT TO TREATMENT OF MINOR CHILD Pt. Initials:

I authorize the licensed doctor and whomever he/she may designate as his/her assistants to administer chiropractic care as he/she so deems necessary to my (relationship):_____(name):_____.

Signature:_____ Date;_____

Female Patients Pt. Initials

This is to certify that to the best of my knowledge I am NOT pregnant and that X-rays may be ordered. Beginning date of your last menstrual period (date)_____

Patient Rights Pt Initials

Vail Chiropractic Clinic P.L.L.C. respects the unique differences of our patient, and will ensure that health care ethics are maintained for all patients. The following rights will be exercised on our patients' behalf.

1. The patient has the right to considerate and respectful care.
2. The patient has the right to and is encouraged to obtain from the doctor relevant, current, and understandable information concerning diagnosis, treatment and prognosis.
3. The patient has the right to know the identity of their clinician and office staff involved in their care.
4. The patient has the right to make decisions about the plan of care prior to and during the course of treatment and to refuse a recommended treatment or plan of care to the extent permitted by law, and to be informed of the consequences of this action.
5. The patient has the right to every consideration of privacy.
6. The patient has the right to expect that all communications and records pertaining to his/her care will be treated as confidential, except in cases when reporting is permitted or required by law.
7. The patient has the right to expect reasonable continuity of care when appropriate and to be informed by the clinician of available and realistic patient care options.
8. The patient has the right to be informed of available resources for resolving disputes, grievances, and conflicts, such as ethics committees, patient representatives, or other mechanisms available in the institution.

Consent to Chiropractic Services Pt Initials

I hereby request and consent to chiropractic manipulations and other procedures including various modes of physical therapy, diagnostic x-ray and/or tests by Vail Chiropractic Clinic P.L.L.C. and their staff who now or in the future treat me while employed by this office. I have had an opportunity to discuss with the doctor named above and/or with other clinic personnel the nature and purpose of treatment indicated. I understand that results are not guaranteed and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, stroke, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgement during the course of any procedure which the doctor feels at the time is in my best interest. I have read, or have had read to me, the full above consent and have also had an opportunity to ask questions about its content and by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for any future conditions for which I seek treatment by this clinic and/or employed staff.

Signature; **Date;**

Witness: **Date;**