The Gleason Center
Your Personal Path to Health

INFORMED CONSENT FOR CARE

Patient Name: _____ **Date of Birth:** ____/____/____

Parent/Guardian Name: _____

A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority for examination and to care for them in accordance with chiropractic tests and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render a patient susceptible to injury, even though a procedure was performed correctly. It must be understood by any patient seeking health care, that no guarantee of results can be made, and that injury, paralysis or death may occur from any procedure performed, and by signing this consent for care form, I acknowledge the risk or danger and choose to have chiropractic procedures performed. The doctor, of course, will not give a chiropractic adjustment or health care if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostics and clinical procedures. The doctor of chiropractic provides a specialized, no-duplicating health service.

DIAGNOSIS

Although doctors of chiropractic are experts in chiropractic diagnosis, they are not medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition.

CHIROPRACTIC

It is important to acknowledge the difference between the heath care specialties of chiropractic, and traditional medicine. Chiropractic care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. A doctor of chiropractic conducts a clinical analysis for the purpose of determining whether there is evidence of Vertebral Subluxation Complexes (VSC). When such VSC are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body, age, occupation and pre-existing conditions.

19084 N. Fruitport Rd.
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RESULTS

The purpose of chiropractic services is to promote natural health through the reduction of the VSC. Since there are so many variables, it is difficult to predict the time schedule of efficacy of the chiropractic procedures. Sometimes the response is immediate. In other cases, it is gradual. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic procedures. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems.

TO THE PATIENT

Please discuss any question or concerns with us before signing this statement of consent.

I have read and understand the foregoing and give my consent to proceed with chiropractic care.

_____

Date

_____

Signature

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Financial Policy

Patient Name:_____ **Date of Birth**:____/____/____

Parent/Guardian Name:_____

____ **Insurance:** Insurance can be a complicated affair and we want to spare you any surprises if we can. The Gleason Center has chosen to accept assignment for Blue Cross/Blue Shield and Priority Health in lieu of cash payment for services. ***As a service to you, we will contact your insurance company to obtain your benefits in relation to chiropractic and massage. The benefits we relay to you are not a guarantee of payment.*** Any copay, co-insurance, deductible, or non-covered service is patient responsibility and due at the time of service. I agree to pay any services my insurance company denies within ten days of denial.

____ **Patients With-Out Insurance**: The Gleason Center does not accept assignment for my insurance company, or I have no third party liable for my health expense. I will be responsible for all payments on my account per fee schedule listed on the back of this sheet. Receipts will be given to me to submit to my insurance carrier for reimbursement. I understand that payment is due at time of service.

____ **Medicare**: The Gleason Center is a non-participating Medicare provider. Forms will be completed and filed for Medicare at no charge. I understand that I am to pay all fees up front and if approved, Medicare will reimburse me directly. Medicare ONLY covers manual manipulation of the spine and any reimbursement will be based upon my benefits.

____ **Worker's Comp, Auto Injury**, etc.: The Gleason Center does not accept assignment on Worker's Comp, Auto Injury, Personal Injury, etc. I will be responsible for all payments on my account per fee schedule listed on back of this sheet. Receipts will be given to me to submit to my insurance carrier for reimbursement. I understand that payment is due at time of service.

**For your convenience we accept cash, checks, Visa, MasterCard, Discover, and American Express.

Appointment Scheduling

We offer text and email reminders as a convenience and a courtesy. It is your responsibility to document your appointment time in case of system error. All appointment changes or cancellations require a 24-hour notice. Your consideration for other patients is appreciated. Failure to provide a 24-hour notice are subject to any fees associated with that appointment. This is not covered by insurance. If you are running late for your appointment, please call, we will do our very best to still see you.

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Fee Schedule: Cash Pay Reflects a Time of Service Discount

New Patient Examination	$170
2nd Visit	$130
Regular Visit	$60
Extended Adjustment 20 min	$110
Extended Adjustment 30 min	$120
Kid's Day Adjustment	$30
Laser treatment	$80
PEMF treatment	$60
Laser package (6 treatments)	$360
Laser package (10 treatments)	$550
Adjustment package (12 reg. adjustments)	$600
Kinesio Tape (1-3 pieces)	$5
Kinesio Tape (4 or more pieces)	$10
Ketone/Glucose Analysis	$5
Urine Analysis	$10
Wellness Assessment	$25

I understand and agree that Dr. Gleason or Dr. Weessies have the right to refuse to accept me at any time before treatment begins. A consultation and the conducting of a physical evaluation/exam are not considered treatment. My signature is an acknowledgement that I understand and agree to the policies stated above. By signing below, I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. I also understand and agree that all services rendered to me are charged to me and that I am personally responsible for payment. If my account is delinquent, I agree to pay all expenses incurred by this office to collect on the account. This includes, but is not limited to, items such as collection agency fees, court costs, and attorney fees. Prices are subject to change at any time.

Wellness Assessment: Is not available to be billed to insurance, this will be an additional $25. This is our doctor's fee as we believe that not all patients are the same and deserve our undivided attention and covers any and all consultation during your regular adjustment appointments.

Returned Checks: In the event that a check is written to this office and it is returned from our bank due to insufficient funds or the account is closed, I agree to pay for the fees of the dishonored check according to the amount allowed under Michigan law. Currently the fee stands at $25 if resolved within 7 business days.

Massage therapy: In order to provide medical necessity for massage therapy with our office a referral by the chiropractor is necessary. Chiropractic visits are ***required*** at least every 90 days as a minimum to document continued medical necessity.

Patient/Guardian Signature Date

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Patient Acknowledgement of Financial Responsibility

Patient Name: _____ **Date of Birth:** ____/____/_____

Parent/Guardian Name: _____

Blue Cross Blue Shield PPO
Blue Cross Blue Shield MESSA
Blue Cross Blue Shield MCR

Priority Health
Priority Health MCR

I hereby authorize: Dr Dan Gleason D.C. and Dr Dan Weessies D.C., M.S.

of: The Gleason Center

To perform the following medical service(s):

S5190-Wellness Assessment, Lab work and Lab Consultations, Nutritional and Supplement Consultations, Kinesio Taping, Laser Treatments, Extended Appointments.

Wellness Assessment: Is not available to be billed to insurance, this will be an additional $25. This is our doctor's fee, as we believe that not all patients are the same and deserve our undivided attention, and covers any and all consultation during your regular adjustment appointments.

For all products and non-covered services (except MCR*):

___ I understand this service(s) has not been authorized and I will be responsible for payment.

___ I understand this service(s) may not be covered by my health care benefits plan, and I will be responsible for payments.

Signature_____ Date_____

*For Medicare members, please use the "Notice of Medicare Non-Coverage"

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Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent For the Use of Health Information

Patients Name_____ DOB: ____/____/____
(Please Print)

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practice Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Date_____

_____
Patient's Signature

If patient is a minor or under guardianship order as defined by State law;

_____
Signature of Parent/Guardian

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Medical Information Release Form (HIPAA Release Form)

Name:_____ DOB:____/____/____

Release of Information

[ ] I authorize the release of information including diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse/Partner:_____

[ ] Parent: _____

[ ] Child(ren):_____

[ ] Other:_____

[ ] Information is not to be released to anyone

This **Release of Information** will remain in effect until terminated by me with a written consent.

Messages

Please call: [ ] My Cell Phone [ ] My Home Phone [ ] My Work

If you are unable to reach me:

[ ] You may leave a detailed message

[ ] Only leave a message asking me to return your call

[ ] Other:_____

_____Date___/___/___
Patient Signature

_____Date___/___/___
Witness

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Last Name:_____ First Name:_____ Birth date:___/___/___ Age:_____

Please Circle: Male or Female Married: Yes No Partner's Name:_____

Additional Members of House Hold:_____

Address:_____City:_____ State:_____ Zip:_____

Cell Phone: _____ Home: _____Email:_____

Guardian/Responsible Party:_____ Medical Insurance Carrier:_____

Primary Physician:_____ Dentist:_____

Employer:_____ Occupation:_____

Who May We Thank For Referring You?_____

Main Issues/Concerns? When Did This Start? How Often? How Long Does It Last? Treatments Used/Tried?

1st _____

2nd _____

3rd _____

4th _____

Indicate Approximate Dates of the Following:

_____Heart Attack
_____High Blood Pressure
_____Low Blood Pressure
_____Diabetes
_____Varicose Veins
_____Hepatitis
_____Acne
_____Broken Bones
_____Orthopedic Surgery
_____Auto Accident
_____Blow to Head
_____Whiplash Injury
_____Serious Fall
_____Nose Bleeds
_____Dentures
_____Bite Adjustment
_____Orthodontic Treatment
_____Periodontal Treatment
_____Sensitive Teeth
_____Difficulty Chewing

_____Root Canal
_____Hypoglycemia
_____Ulcers
_____Constipation
_____Diarrhea
_____Heartburn
_____Poor Digestion
_____Stomach Gas
_____Gall Bladder
_____Hemorrhoids
_____Kidney Issues
_____Frequent Urination
_____Urgent Urination
_____Cancer
_____Mononucleosis
_____Canker Sore
_____Fatigue
_____Anemia
_____Arthritis /Bursitis
_____Tendinitis

_____Muscle Cramps
_____Nervousness
_____Vertigo
_____Epilepsy
_____Difficulty Sleeping
_____Depression
_____Psychotherapy
_____Eye Pain/Pressure
_____Sensitivity to Light
_____Sinus Trouble
_____ MS

Headaches:
Location:_____
_____Migraines
_____Tension
_____Sinus
_____ Stress
_____Cluster
_____TMJ

_____ Cold Hands or Feet (please circle one)
_____Numb Hands or Feet (please circle one)
_____Nerve Pain; Location:_____
_____Swollen Feet or Ankles

Pain or Stiffness:
_____Shoulders
_____Neck
_____Mid Back
_____Low Back
_____Other, Explain:_____

Women Only:

_____Menstrual Problems
_____Mood/Memory Issues
_____Post-Partum Depression
_____Age at 1st Menses
_____Number of Miscarriage(s)

_____ Excessive Flow
_____Breast Tenderness
_____Hysterectomy
_____Number of Pregnancies

_____Clotting or Dark Flow
_____Menopause
_____Uterine Ablation
_____Number Of Children

_____Cramping
_____Hot Flashes
_____PMS

Have You Experienced Any Of The Following?

Please Indicate Approximate Dates:

_____Death of a Loved One

_____Illness or Injury of Family or Friend

_____Marriage

_____Loss or Change of Job

_____Retirement

_____Pregnancy or Birth of Child

_____Sexual Problems

_____Change in Personal Habits

_____Change in Living Conditions

Please Elaborate:_____

_____

Work and Daily Life:

_____Exposure to Fumes

_____Exposure to Chemicals

_____Mental Stress

_____Physical Stress

_____Sitting _____Standing for Long Periods

_____Bending Frequency_____

_____Lifting Weight_____

_____Working Overhead

What Do You Like About Your Job?_____

_____

Environmental Allergies:_____

_____

Rest:

How Do You Sleep?

_____Stomach _____Side L or R _____Back

Hours per night:_____ Third Shift:_____

Do you wake up: _____Rested _____Tired

Problems: Falling Asleep_____ Staying Asleep_____

Elimination:

Bowel Movements Per Day:_____

BM's: Hard___ Soft___ Loose___ Watery___ Normal___

Other:_____

For Office Use Only:

_____

_____

_____

_____

_____

_____

_____

_____

Diet:

Typical Breakfast:_____

Typical Lunch:_____

Typical Dinner:_____

Snacks:_____ Time of Day_____

Times You Eat Out Per Week:_____

Type of Restaurants:_____

Number of Cups Per Day: Water_____ Coffee _____
Milk _____Pop_____ Alcohol_____

City Water:_____ Well Water:_____

Number of Cigarettes Per Day:_____

Known Food Allergies:_____

_____

Physical Activity:

What Does Your Normal Exercise Program Include?

Type of Exercise:_____

Hours Per Day:_____ Days Per Week:_____

Type of Exercise:_____

Hours Per Day:_____ Days Per Week:_____

Type of Exercise:_____

Hours Per Day:_____ Days Per Week:_____

Type of Exercise:_____

Hours Per Day:_____ Days Per Week:_____

Type of Exercise:_____

Hours Per Day:_____ Days Per Week:_____

Date of Last Physical:_____

Date of Last Dental Exam:_____

Vaccine History:_____

_____

_____

_____

_____

List Your Medications and Reasons for Taking:

_____

_____

_____

_____

_____

_____

_____

List Your Vitamin Supplements:

_____

_____

_____

_____

_____

_____

_____

_____