Pennridge Wellness Center Informed Consent:

CHIROPRACTIC: I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy and diagnostic x-rays, on me for on the name of the patient below for whom I am legally responsible for by Dr. Johanna L. Garlan, Dr. Lindsey Wilder and/or any other licensed doctors of chiropractic who now or in the future will be with The Pennridge Wellness Center.

I understand 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, 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 reply upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time based upon the facts that known to him or her, is in my best interest.

I understand that results are not guaranteed. I have read the above consent. I understand I have the opportunity to ask questions about its consent, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I have received the Chiropractic Clinic's Notice of Privacy Practices for protected health information (Request a copy if needed.)

Although no outcome of treatment can be guaranteed, it is understood that every patient is unique and that each treatment is designed specifically for the condition of the patient.

Print Patient's Name: _____
Patient or Guardian's Signature:_____ Date:_____

ACUPUNCTURE: Acupuncture is the insertion of a thin needle into the surface of the body. A patient may feel a slight pricking sensation near the needle. Patients usually report little or no pain during an acupuncture treatment.
Side Effects: The following side effects may occur and are not limited to the following:
a. Some pain following treatment in the insertion location (uncommon)
b. Minor bleeding from insertion location (occasionally)
c. Minor bruising (occasionally)
d. Infection (rare)
e. Needle sickness (feeling faint or dizzy, rare)
f. Broken needle (almost unheard of)
(There are many other potential side effects of treatment which are much more common:
acquisition of a deeply relaxed state, drugless relief of our condition, enhanced well-being, improved immunity and increased mental clarity and insight.)

Although no outcome of treatment can be guaranteed, it is understood that every patient is unique and that each treatment is designed specifically for the condition of the patient. With this knowledge, I give my informed and voluntarily consent to the above procedures.

Print Patient's Name: _____
Patient or Guardian's Signature:_____ Date:_____

Pennridge Wellness Center Authorization, Release, and Financial Polices:

I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of my insurance coverage.

PLEASE NOTE: Insurance companies do not pay for care that is not medically-necessary. If you or your child does not have a musculoskeletal complaint, he/she does not qualify for insurance coverage.

I do understand that insurance companies do not pay for services that they determine to be not "medically necessary" and therefore, may deny payment for services provided to me by the chiropractor. However, I clearly understand and agree that all services rendered to me are my personal responsibility and I am securing my account with the credit card given at time of check in. If payment hasn't been received in 10 days from terminating any care, I authorize deduction from my credit card for any balance that may have accrued. If for any reason a patient has pre-paid for care and no longer wishes to continue, a refund for the remaining care will be issued.

Privacy:
I understand and agree to allow this chiropractic office to use my patient health information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your patient health information is going to be used in this office and your rights concerning those records. The following person(s) have my permission to receive my personal health information:

Name of person: _____ Relationship: _____

The Pennridge Wellness Center is always pleased when patients are willing to communicate the stories, experiences, and information about their treatment received at our office. Sharing your story can help others who are interested in knowing more about the services provided by our office!

The PWC respects the privacy of our patients, visitors, and staff. Ensuring that medical information is kept confidential is among our highest priorities. PWC seeks your permission to use your medical information and your consent to allow us to take and use audio/video/photographic material of you in internal and external communications, including medical and general interest publications, medical and patient education information, and distribute such materials online, in print, and in news media (such as TV, radio, newspapers, and magazines).

To ensure that the PWC is acting in accordance with your wishes, and using your personal information with your authorization, we ask you to fill out and sign below. PWC will keep a copy of your written permission on file.

Patient or Guardian's Signature: _____Date: _____

Cancellation Policy:
The Pennridge Wellness Center requires a 24 hour cancellation notice for acupuncture and massage appointments. If 24 hours is not given, PWC reserves the right to charge the full amount of the visit.

Patient or Guardian's Signature: _____Date: _____