CHIROPRACTIC AND ALTERNATIVE HEALTH SERVICES

M. J. Krygier, B.A., B.S., D.C.
24360 Novi Rd. Suite B-1
Novi, MI 48375

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understands the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of force to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spine 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.

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 services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I_____have read and fully understand the above statements.
(*Print name*)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(*Signature*) (*Date*)

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____ _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

PATIENT NAME_____ #_____

SIGN BELOW WHERE APPROPRIATE

FINANCIAL RESPONSIBILITY

I agree to be financially responsible for all charges incurred at this office, including my insurance deductible, co-payment, and any services rejected by my insurance company.

PATIENT'S SIGNATURE_____ DATE_____

ASSIGNMENT

I herby instruct and direct my insurance company to pay by check, made out and mailed directly me, the professional or medical expense benefit allowable, as payment toward the total charge for professional services rendered by this office.

PATIENT'S SIGNATURE_____ DATE_____

RELEASE OF INFORMATION

I authorize this office to release any information pertinent to my case to any insurance company, adjuster and attorney involved in this case, and herby release this office of any consequence thereof.

PATIENT'S SIGNATURE_____ DATE_____

MEDICARE ONLY

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Michael Krygier for any services furnished to me by this physician. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formally known as Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable for related services.

PATIENT'S SIGNATURE_____ DATE_____

X-RAY CONSENT FORM

If x-rays are needed, the doctor will explain that the purpose of the x-rays is to analyze the spine for vertebral subluxations and to determine the appropriateness of chiropractic spinal adjustments. If the doctor discovers a non-chiropractic "unusual finding" when reviewing this x-ray, I will be informed. I then must determine if I should seek the services of an additional health care provider for advice, diagnosis, or treatment for the unusual finding. I understand that seeking advice from another type of health care provider should not interfere with the subluxation corrective care provided by this office.

PATIENT'S SIGNATURE_____ DATE_____

PREGNANCY RELEASE

This is to certify that to the best of my knowledge, I am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period:_____

PATIENT'S SIGNATURE_____ DATE_____

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Consent to Recommended Treatment

It has been explained to me, and I understand that Dr. Krygier is a Chiropractor, and not a medical or osteopathic physician. As a result, this practice and the care provided is limited to that which is permitted by State Law. We do not provide the type of care or treat conditions that fall within the scope of practice of Medical Doctors, and do not treat or offer cures for diseases of illnesses such as cancer, diabetes, or other similar conditions.

Dr. Krygier may provide nutritional advice or support. I understand that this advice and support is provided for general health and is not offered as treatment for a disease or illness. Medical doctors or specialists must treat any disease or illness that you may have.

I have read this statement, I have had the opportunity to discuss it with the staff, and agree with it. I acknowledge that Dr. Krygier is not treating me for any disease or illness and agree not to hold him responsible for any such condition.

With this knowledge, I freely and willingly consent to the recommended course of treatment.

Patient signature: _____ Date: _____

Staff Signature: _____ Date: _____