

Cornerstone Chiropractic

Dr. Michael J. Ilyankoff Dr. Lisa M. Ilyankoff 2003 132nd Street SE, Ste. E, Everett, WA 98208 (425) 379-6301

Terms of Acceptance ♦ Informed Consent for Care

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 understand both 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 forces to facilitate the body's correction of the 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 or infirmity.

Vertebral subluxation: A misalignment of one or more of the 24 vertebrae on the spinal 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 it's maximum potential.

Results: The purpose of chiropractic services is to provide health through the release of maximum nervous energy. Since there are so many variables, it is difficult to predict the time schedule and efficiency of chiropractic procedures. Sometimes the results are phenomenal. In some cases, there is a more gradual response, and occasionally the results are less than expected. Many people find results with chiropractic care, in turn we must admit that conditions which do not respond chiropractically, may come under the control of medical sciences. We will do our very best in determining if you need chiropractic care, however we cannot be held responsible for a medical diagnosis, or, under the Wisconsin trail law, be responsible for a medical referral.

We do not offer to diagnose or treat any disease or condition other than the 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 service 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 the vertebral subluxation.

I, _____, have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction and I agree with the above statements.

I therefore accept chiropractic care (including Chiropractic Examination, X-ray, and Adjustments) on this basis.

Signature _____ Date _____

Consent to treat a Minor

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 evaluation (including X-ray examination) and care.

Signature _____ Date _____

Pregnancy Release (all female patients age 10 and older)

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and 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: _____

Signature _____ Date _____

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BILLING INFORMATION:

Name of person responsible for this account _____ Relationship to patient _____

Will we be billing your health insurance? Yes No

HEALTH INSURANCE

Health Insurance Co. Name: _____

ID # _____ Group # _____

Policy Holder: _____ Relationship to patient _____

Policy Holder's address (if different than patient's) _____

Policy Holder's Date of Birth _____ Policy Holder's Social Security Number _____

If you have Secondary Insurance coverage, please let the front desk know.

AUTO ACCIDENT

Will we be billing your Personal Injury Protection (PIP)? Yes No

Your Auto Insurance Company _____ Phone # _____

Insurance Address _____

Claim Number _____ Adjuster's Name _____

Policy Holder: _____ Relationship to patient _____

Policy Holder's address (if different than patient's) _____

Policy Holder's Date of Birth _____ Policy Holder's Social Security Number _____

Insurance of At-fault party(if other than above) _____ Phone # _____

Claim Number _____ Adjuster's Name _____

Insurance Address _____

L&I/WORK INJURY

Claim Number _____ Date of Injury _____

Claims Adjuster _____ Adjuster's phone number _____

Is your claim through L&I or a Self Insured company? _____

Address of Self Insured company (if applicable) _____

Has your claim been opened by another health care provider? _____

Insurance Billing Policy: If you have coverage for chiropractic care, our office will bill your insurance company as a courtesy to you. You will be responsible for your deductible, co-payment or co-insurance at the time services are rendered. Please remember, services are rendered to you, the patient, and not to the insurance company. You are ultimately responsible for your bill, REGARDLESS OF INSURANCE PAYMENT.

AUTHORIZATION: I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Cornerstone Chiropractic, Dr. Michael J. Ilyankoff, and Dr. Lisa M. Ilyankoff to release any information including the diagnosis and records of any treatment or examination rendered to me, or my child, during the period of such chiropractic care to third party payers. I authorize and request my insurance company to pay directly to Cornerstone Chiropractic, Dr. Michael Ilyankoff, or Dr. Lisa M. Ilyankoff insurance benefits otherwise payable to me. I fully understand that I am directly and fully responsible to said doctor or his/her office for all health care bills submitted by them for services rendered me regardless of payment by applicable insurance company/companies.

Signature _____ Date _____