Dr. Sergio Niño, L.I.F.E. Chiropractic Center P.L.L.C

2333 W. Northern Ave
Sutie 1B
Phoenix, AZ 85021

WELCOME TO OUR OFFICE

We are committed to providing you the best care and are pleased to discuss our professional fees with you at anytime. Your clear understanding of our financial policy is important to our professional relationship. Please ask any questions you may have regarding our fees or your responsibility in complying with our financial policy and/or procedures.

- **Cash Patients:** Payment is due when services are rendered. We gladly accept Master Card, Visa, check or cash.

- **Insurance Patients:** Please pay 20%, or your co-insurance %, for your first visit charges. Professional services are rendered and charged to your insurance on your behalf. Any services not covered by your insurance are ultimately your responsibility and may have to be paid by you at the time of service. If you fail to keep your scheduled appointments or if you discontinue care for any reason other than discharge by the doctor, the bill is due and payable by you in full, immediately, regardless of any insurance claims submitted. Our office accepts billing for Individual or Group Insurance policies, Personal Injury claims, authorized Worker's Compensation and Medicare.

- **Collection/Attorney Fees:** I agree to pay all costs of a collection agency if necessary to obtain payment in the event legal action should become necessary to collect an unpaid balance due for medical services. I agree to pay reasonable attorney's fees or other such costs as the court determines proper.

- **Authorization to Process Drafts:** I agree that L.I.F.E CHIROPRACTIC CENTER shall be appointed as my agent to endorse drafts on any checks for payment of my bill for medical services rendered.

- **Limited Release of Medical Information:** I authorize L.I.F.E CHIROPRACTIC CENTER to make inquiries and to release any pertinent information to any insurance company, government agency, adjuster or attorney to facilitate collection under these assignments.

- **Assignment of Cause of Action:** In the event that any insurance company or other third party obligated to make payment to me or to L.I.F.E CHIROPRACTIC CENTER for the charges made for the services, refuses to make such payment upon demand, I hereby assign, transfer and convey to L.I.F.E CHIROPRACTIC CENTER any and all cause of action that might exist in my favor against any such company or person. I authorize L.I.F.E CHIROPRACTIC CENTER to prosecute said action in my name or their name to collect fees due for care rendered and legal expenses, and to resolve said claims as they see fit.

- **Authorization for Open Adjustment**

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

- The nature of chiropractic treatment: The doctor will use his/her hands and or mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may fell movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

- **Possible Risks:** As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves, or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. PLEASE ASK YOUR DOCTOR TO EXPLAIN THE TECHNIQUE AND/OR EXTRA SAFEGUARDS PRACTICED TO ENSURE SUCH HAPPENINGS DO NOT OCCUR. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns, or minor complications.

- **Probability of Risks Occurring:** The risk of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare."

- **Other treatment options which could be considered** may include the following:

    - Over-the-counter analgesics. The risks of these medications include irritation to stomach, liver, and kidneys, and other side effects in a significant number of cases
    - Medical care, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
    - Hospitalization in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases
    - Surgery in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended covalescent period in a significant number of cases.

- **Risks of remaining untreated:** Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reudce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatement will complicate the condition and make future rehabilitation more difficult.

- **Unusual risks:** I have had the followin gunusual risks of my case explained to me.:

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to uundergo the recommended treatemtn, and hereby give my full consent to treatment.

_____	_____	_____
Printed Name	Signature	Date

WITNESS

_____	_____	_____
Printed Name	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 Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:

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

_____ _____
Sign Date