Cornerstone Chiropractic Inc PS
Dr. Michael J. Ilyankoff ◆ ◆ ◆ Dr. Lisa M. Ilyankoff
2003 132nd Street SE, Suite 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 for the same objective. 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. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____ _____ _____

Print Name 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 or massage therapy.

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) _____Employer: _____

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 or massage therapy, our office will bill your insurance company as a courtesy to you. You will be responsible for your deductible, co-payment or co-insurance <u>at the time services are rendered</u>. 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.

<u>AUTHORIZATION</u>: 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 or massage therapy to third party payers. I authorize and request my insurance company to pay directly to Cornerstone Chiropractic Inc, PS, 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_____