The Gleason Center
Your Personal Path to Health

INFORMED CONSENT FOR CARE

Patient Name: _____ Date of Birth: _____/_____/_____

Parent/Guardian Name: _____

A patient, in coming to the Doctor of Chiropractic, gives the doctor permission and authority for examination and to care for them in accordance with chiropractic tests and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render a patient susceptible to injury, even though a procedure was performed correctly. It must be understood by any patient seeking health care, that no guarantee of results can be made, and that injury, paralysis or death may occur from any procedure performed, and by signing this consent for care form, I acknowledge the risk or danger and choose to have chiropractic procedures performed. The doctor, of course, will not give a chiropractic adjustment or health care if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostics and clinical procedures. The doctor of chiropractic provides a specialized, no-duplicating health service.

DIAGNOSIS

Although doctors of chiropractic are experts in chiropractic diagnosis, they are not medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition.

CHIROPRACTIC

It is important to acknowledge the difference between the heath care specialties of chiropractic, and traditional medicine. Chiropractic care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. A doctor of chiropractic conducts a clinical analysis for the purpose of determining whether there is evidence of Vertebral Subluxation Complexes (VSC). When such VSC are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body, age, occupation and pre-existing conditions.

Lakeshore Integrative Health Center
19084 N. Fruitport Rd.
Spring Lake, MI 49456
www.thegleasoncenter.com info@thegleasoncenter.com
Phone: 616-846-5410 Fax: 616-846-3585

The Gleason Center
Your Personal Path to Health

RESULTS

The purpose of chiropractic services is to promote natural health through the reduction of the VSC. Since there are so many variables, it is difficult to predict the time schedule of efficacy of the chiropractic procedures. Sometimes the response is immediate. In other cases, it is gradual. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic procedures. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems.

TO THE PATIENT

Please discuss any question or concerns with us before signing this statement of consent.

I have read and understand the foregoing and give my consent to proceed with chiropractic care.

_____

Date

_____

Signature

Lakeshore Integrative Health Center
19084 N. Fruitport Rd.
Spring Lake, MI 49456
www.thegleasoncenter.com info@thegleasoncenter.com
Phone: 616-846-5410 Fax: 616-846-3585

The Gleason Center
Your Personal Path to Health

Financial Policy

Patient Name:_____ **Date of Birth**:____/____/____

Parent/Guardian Name:_____

___ Insurance: Insurance can be a complicated affair and we want to spare you any surprises if we can. Lakeshore Integrative Health Center has chosen to accept assignment for Blue Cross/Blue Shield, Priority Health, and Aetna in lieu of cash payment for services. ***As a service to you, we will contact your insurance company to obtain your benefits in relation to chiropractic. The benefits we relay to you are not a guarantee of payment.*** Any copay, co-insurance, deductible, or non-covered service is the patient's responsibility and due at the time of service. I agree to pay for any services my insurance company denies within ten days of denial.

____ **Non-Billable Insurance/Cash Pay Patients**: Lakeshore Integrative Health Center does not accept assignment for my insurance company, or I have no third party liable for my health expense. I will be responsible for all payments on my account per fee schedule listed on the back of this sheet. Receipts will be given to me to submit to my insurance carrier for reimbursement. I understand that payment is due at the time of service.

____ **Medicare**: Lakeshore Integrative Health Center is a non-participating Medicare provider. I understand my insurance will not be billed and I understand payment is due at the time of service.

____ **Worker's Comp, Auto Injury**, etc.: Lakeshore Integrative Health Center does not accept assignment on Worker's Comp, Auto Injury, Personal Injury, etc. I will be responsible for all payments on my account per fee schedule listed on back of this sheet. Receipts will be given to me to submit to my insurance carrier for reimbursement. I understand that payment is due at the time of service.

**For your convenience we accept cash, checks, Visa, MasterCard, Discover, and American Express. Cash and check payments may be subject to discounted prices on services and products.

Appointment Scheduling

We offer text and email reminders as a convenience and a courtesy. It is your responsibility to document your appointment time in case of a system error. All appointment changes or cancellations require 24-hour notice. Your consideration for other patients is appreciated. Failure to provide a 24-hour notice is subject to any fees associated with that appointment. This is not covered by insurance. If you are running late for your appointment, please call, we will do our very best to still see you.

Lakeshore Integrative Health Center
19084 N. Fruitport Rd.
Spring Lake, MI 49456
www.thegleasoncenter.com info@thegleasoncenter.com
Phone: 616-846-5410 Fax: 616-846-3585

The Gleason Center
Your Personal Path to Health

Non-insurance Fee Schedule:

New Patient Examination	$176
2nd Visit	$136
Regular Visit	$63
Extended Adjustment 20 min	$116
Extended Adjustment 30 min	$136
Kid's Day Adjustment	$33
Laser treatment	$85
PEMF treatment	$65
Laser package (6 treatments)	$375
Laser package (10 treatments)	$570
Adjustment package (12 reg. adjustments)	$630
Kinesio Tape (1-3 pieces)	$6
Kinesio Tape (4 or more pieces)	$11
Ketone/Glucose Analysis	$5
Urine Analysis	$10
Wellness Assessment	$28

*****Discounts may be available if payments are remitted with cash or check*

I understand and agree that Dr. Gleason or Dr. Weessies have the right to refuse to accept me as a patient at any time before or after my treatment begins. A consultation and the conducting of a physical evaluation/exam are not considered treatment.
My signature is an acknowledgement that I understand and agree to the policies stated within this document. By signing below, I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. I also understand and agree that all services rendered to me are charged to me and that I am personally responsible for payment. If my account is delinquent, I agree to pay all expenses incurred by this office to collect on the account. This includes, but is not limited to, items such as collection agency fees, court costs, and attorney fees. Prices are subject to change at any time.

Wellness Assessment: Is not available to be billed to insurance, this will be an additional $28. This is our doctor's fee as we believe that not all patients are the same and deserve our undivided attention and covers any and all consultation during your regular adjustment appointments. This fee will be discounted when payment is remitted with cash or check.

Returned Checks: In the event that a check is written to this office, and it is returned from our bank due to insufficient funds or the account is closed, I agree to pay for the fees of the dishonored check according to the amount allowed under Michigan law. Currently the fee stands at $30 if resolved within 7 business days.

Massage Therapy: To provide medical necessity for massage therapy with our office a referral by the chiropractor is necessary. Chiropractic visits are ***required*** at least every 90 days as a minimum to document continued medical necessity.

_____ _____

Patient/Guardian Signature **Date**

Lakeshore Integrative Health Center
19084 N. Fruitport Rd.
Spring Lake, MI 49456
www.thegleasoncenter.com info@thegleasoncenter.com
Phone: 616-846-5410 Fax: 616-846-3585

The Gleason Center
Your Personal Path to Health

Patient Acknowledgement of Financial Responsibility

Patient Name: _____ **Date of Birth:** ____/____/_____

Parent/Guardian Name: _____

Blue Cross Blue Shield	**PPOPriority Health**
Blue Cross Blue Shield MESSA	**Priority Health MCR**
Blue Cross Blue Shield MCR	**Aetna / Medicare**

I hereby authorize: Dr Dan Gleason D.C. and Dr Dan Weessies D.C., M.S.___

of: Lakeshore Integrative Health Center_____

To perform the following medical service(s):

S5190-Wellness Assessment, Lab work and Lab Consultations, Nutritional and Supplement Consultations, Kinesio Taping, Laser Treatments, Extended Appointments.

Wellness Assessment: Is not available to be billed to insurance, this will be an additional $28. This is our doctor's fee, as we believe that not all patients are the same and deserve our undivided attention and covers any and all consultation during your regular adjustment appointments.

Discounts will be applied to payments remitted with cash or check

For all products and non-covered services (except MCR*):

___ I understand this service(s) has not been authorized and I will be responsible for payment.

___ I understand this service(s) may not be covered by my health care benefits plan, and I will be responsible for payments.

_____ _____

Patient/Guardian Signature **Date**

*For Medicare members, please use the "Notice of Medicare Non-Coverage" Form

Lakeshore Integrative Health Center
19084 N. Fruitport Rd.
Spring Lake, MI 49456
www.thegleasoncenter.com info@thegleasoncenter.com
Phone: 616-846-5410 Fax: 616-846-3585


The Gleason Center
Your Personal Path to Health

The Gleason Center
Your Personal Path to Health

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent For the Use of Health Information

Patients Name_____ DOB: _____/_____/_____
(Please Print)

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practice Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Date_____

_____
Patient's Signature

If patient is a minor or under guardianship order as defined by State law;

_____
Signature of Parent/Guardian

Lakeshore Integrative Health Center
19084 N. Fruitport Rd.
Spring Lake, MI 49456
www.thegleasoncenter.com info@thegleasoncenter.com
Phone: 616-846-5410 Fax: 616-846-3585


The Gleason Center
Your Personal Path to Health

The Gleason Center
Your Personal Path to Health

Medical Information Release Form (HIPAA Release Form)

Patient Name:_____ DOB:____/____/____

Release of Information

[ ] I authorize the release of information including diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse/Partner:_____

[ ] Parent: _____

[ ] Child(ren):_____

[ ] Other:_____

[ ] Information is not to be released to anyone

This **Release of Information** will remain in effect until terminated by me with a written consent.

Messages

Please call: [ ] My Cell Phone [ ] My Home Phone [ ] My Work

If you are unable to reach me:

[ ] You may leave a detailed message

[ ] Only leave a message asking me to return your call

[ ] Other:_____

_____ Date____/____/_____
Patient Signature

_____ Date____/____/_____
Parent or Guardian Signature

_____ Date____/____/_____
Witness

Lakeshore Integrative Health Center
19084 N. Fruitport Rd.
Spring Lake, MI 49456
www.thegleasoncenter.com info@thegleasoncenter.com
Phone: 616-846-5410 Fax: 616-846-3585


The Gleason Center
Your Personal Path to Health

The Gleason Center
Your Personal Path to Health

Last Name: _____ First Name: _____ Birthdate: ____/____/_____ Age: ____
Please Circle: Male or Female Married: Yes No Partner's Name: _____
Additional Members of Household: _____
Address: _____ City: _____ State: _____ Zip: _____
Cell: _____ Home: _____ Email: _____
Guardian/Responsible Party: _____ Medical Insurance Carrier: _____
Primary Physician: _____ Dentist: _____
Employer: _____ Occupation: _____
Who May We Thank for Referring You? _____

Main Issues/ Concerns **Start Date** **How Often & Length of Time?** **Treatments Used/Tried**

1st _____

2nd _____

3rd _____

4th _____

Indicate Approximate Date of the Following:

_____ Heart Attack
_____ High Blood Pressure
_____ Low Blood Pressure
_____ Diabetes
_____ Varicose Veins
_____ Hepatitis
_____ Acne
_____ Broken Bones
_____ Orthopedic Surgery
_____ Auto Accident
_____ Blow to the Head
_____ Whiplash Injury
_____ Serious Fall
_____ Nose Bleeds
_____ Dentures
_____ Bite Adjustment
_____ Orthodontic Treatment
_____ Periodontal Treatment
_____ Sensitive Teeth
_____ Difficulty Chewing

_____ Root Canal
_____ Hypoglycemia
_____ Ulcers
_____ Constipation
_____ Diarrhea
_____ Heartburn
_____ Poor Digestion
_____ Stomach Gas
_____ Gall Bladder
_____ Hemorrhoids
_____ Kidney Issues
_____ Frequent Urination
_____ Urgent Urination
_____ Cancer
_____ Mononucleosis
_____ Canker Sore
_____ Fatigue
_____ Anemia
_____ Arthritis/ Bursitis
_____ Tendinitis

_____ Muscle Cramps
_____ Nervousness
_____ Vertigo
_____ Epilepsy
_____ Difficulty Sleeping
_____ Depression
_____ Psychotherapy
_____ Eye Pain/ Pressure
_____ Sensitivity to Light
_____ Sinus Trouble
_____ MS

Headaches:
Location: _____
_____ Migraines
_____ Tension
_____ Sinus
_____ Stress
_____ Cluster
_____ TMJ

Pain and/or Stiffness:
_____ Neck
_____ Shoulders
_____ Mid Back
_____ Lower Back
_____ Other-Explain:
_____
_____ Cold Hands or Feet
_____ Numb Hands or Feet
_____ Nerve Pain
_____ Swollen Feet or Ankles

Women Only:

_____ Age at 1st Menses
_____ Menstrual Problems
_____ Mood/ Memory Issues
_____ Excessive Flow
_____ Breast Tenderness
_____ Clotting/ Dark Flow

_____ Cramping
_____ Nausea
_____ Headaches
_____ Irregular Cycle
_____ Number of Pregnancies
_____ Number of Children

_____ Number of Miscarriages
_____ Post-Partum Depression
_____ Menopause
_____ Hot Flashes
_____ Hysterectomy
_____ Uterine Ablation

The Gleason Center
Your Personal Path to Health

Have you experienced any of the following?
Please indicate approximate date:
____ Death of Loved One
____ Illness or Injury of family or close friend
____ Marriage
____ Divorce
____ Loss or Change of Job
____ Retirement
____ Pregnancy or Birth
____ Sexual Problems
____ Change of Living Condition
____ Change of Personal Habits
____ Other- Explain: _____
_____

Work and Daily Life Habits:
_____ Exposure to Fumes / Chemicals
_____ Mental Stress
_____ Physical Stress
_____ Sitting
_____ Standing for long periods
_____ Bending – Frequency _____
_____ Lifting – Weight _____
_____ Working Overhead
What do you love about your Job? _____
_____
Environmental Allergies: _____
_____

Rest – How do you sleep?
_____ Stomach _____ Side (L or R) _____ Back
Hours per night: _____ Third Shift: _____
Do you wake up feeling: _____ Rested _____ Tired
Problems: _____ Falling Asleep _____ Staying Asleep

Digestive Health – Bowel Habits
Bowel movements per day: _____
Consistency: ____Hard ____Soft/Normal ____Loose
____ Watery Other: _____

Doctors Notes	**Office Use Only**

Diet:
Typical Breakfast:_____
Typical Lunch: _____
Typical Dinner: _____
Snacks: _____ Time of Day: _____
Times you Eat Out Weekly: _____
Type of Restaurants: _____
Cups per day (8oz): _____Water _____ Coffee
_____ Milk _____ Pop _____ Alcohol
_____ City or Well Water at home?
Known Food Allergies/Intolerance: _____
_____
Cigarettes per day: _____ Vape? _____

Physical Activity:
What does your normal exercise program include?
Type of Exercise: _____
Hours Per Day: _____Days Per Week: _____
Type of Exercise: _____
Hours Per Day: _____ Days Per Week: _____
Type of Exercise: _____
Hours Per Day: _____ Days Per Week: _____
Type of Exercise: _____
Hours Per Day: _____ Days Per Week: _____

Date of Last Physical: _____
Date of Last Dental Exam: _____
Vaccine History: _____
_____
_____
_____
_____

Medications – Include reason, dose, and start date:
_____
_____
_____
_____
_____
_____

Supplements:
_____
_____
_____
_____
_____
_____