Chelsea Markus, D.C. PLLC
Located Within
Oakland Sports Chiropractic
106 W Shadbolt Rd
Lake Orion, MI 48326

Dr. Chelsea Markus Hauswirth D.C.
Phone: 9248) 783-7169
Fax: (248) 929-8077

First Name: _____ Last Name: _____ Middle Initial: _____ Date: _____

Functional Medicine Informed Consent

Functional Medicine with Muscle Testing Terms of Acceptance

Our doctor and support staff are dedicated to providing you with the best health care possible, with the goal of you reaching your optimal health and function. When a patient seeks to improve his or her overall health through a combination of Functional Medicine and Muscle Testing with a chiropractic physician, it is essential for both to be working towards the same objective. It is important that each patient understand both the objective and the method that will be used to attain it.

Prior to receiving care from Chelsea Markus D.C. PLLC, a health history and physical examination will be completed. These procedures are performed to assess your specific condition and your overall health. In addition, they will help determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care. The doctor will not be held responsible for any pre-existing medical diagnosed conditions nor for any medical diagnosis.

It is important to note; we do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxation or neuro-musculoskeletal conditions. However, if during the course of an examination, we encounter non-chiropractic or unusual findings, we will advise you. Regardless of what the disease is called, we do not offer to treat it.. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. If you are undergoing a Functional Medicine examination, you will be notified if vertebral subluxations are encountered.

In the state of Michigan, the scope of chiropractic practice covers the correction of vertebral subluxation. However, we may use other procedures such as nutrition recommendations, lifestyle modifications, and exercise for total body wellness.

Cancellation and No-Show Policy:

No shows and cancellations made less than 2 business days before your scheduled time will be charged the full appointment fee. This balance will need to be paid before you can schedule a follow up appointment. After 2 no shows or last-minute cancellations you will be charged for your full missed appointment and you will have to pay upfront for your next appointment.

Functional Medicine with Muscle Testing Fees:

Initial Consultation: Up to 90 Minutes in Duration: $300

Follow Up Consultations: 30/45/60 Minutes in Duration: $100/$150/$200

If the Visit Goes over the Allotted Time: $3.00 per minute charge will be applied

I understand that all Functional Medicine Muscle Testing Consultations will not be billed to my insurance company and therefore payment is my responsibility at the time of service.

Signature: _____ Date: _____

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Agreements and Authorization

Consent to health care services/ Release of health care information

You (the undersigned patient, or undersigned person responsible for consenting on patients behalf) hereby request and consent to patient health care services from Chelsea Markus D.C. PLLC. The patient health care services will be provided by licensed, treating chiropractor. I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic health care in a private treatment area and I give authority for these procedures to be performed. I also give authority for confirmation of my appointments via telephone answering machines or services as well as text and/or email if I have provided you with the pertinent information. Medical, nursing, and other health care personnel who are in training may also participate in the patients care as part of their education.

Initial: _____

Responsibility for personal property

You accept sole responsibility for all patient property, except for property expressly accepted by Chelsea Markus D.C. PLLC for safekeeping under its sole care and custody.

Initial: _____

Chiropractic Manual Medicine:

You can choose to incorporate chiropractic manual medicine into your wellness care from Chelsea Markus D.C., PLLC if recommended by the doctor. Chiropractic manual medicine, like all forms of health care, while offering considerable benefit, may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic manual medicine include sprain/strain injuries, irritation of a disc condition, and rarely, fractures

Adjustment: An adjustment is the specific application of forces 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 or infirmity.
Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in 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 its maximum health potential.

Initial: _____***N/A***

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Consent to evaluate and treat a minor/dependent

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 be treated at Chelsea Markus D.C. PLLC as often as the doctor suggests indicated by verbal or written treatment plan.

I also hereby authorize _____ to schedule appointments and be treated without a parent or guardian present.

Initial: _____N/A

Patient Privacy acknowledgement

For use and/or disclosure of Protected Health Information (PHI) to carry out treatment, payment, and healthcare operations:

I_____, hereby state that by signing this consent I acknowledge and agree as follows:

I. The practice's Privacy Notice has been provided to me prior to my signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the practice to provide treatment. The practice explained to me that the privacy notice would be available to me in the future at my request. The practice has further explained my right to obtain a copy of the privacy notice prior to signing this consent, and has encouraged me to read the privacy notice carefully prior to my signing this consent.

II. The practice reserves the right to change its privacy practices that are described in the privacy notice, in accordance with applicable law

III. The practice "notice of privacy practices" is also provided on request at the main administration desk of this practice. I may obtain a revised Notice of Privacy Practice by calling the office and requesting a revised copy be sent in the mail, ask for one at the time of my next appointment. I may also request a copy from this office at any time via US Mail.

IV. This notice of privacy practices also describes my rights and duties of this office with respect to my PHI.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Printed Name: _____ Date: _____

Signature: _____ Date: _____

Witness: _____ Date: _____