Great Lakes Chiropractic of St. Michael
116 Central Ave East St. Michael, MN 55376
PH: 763-515-6650 | FAX: 763-777-9186

2026 Policies and Authorizations

Please review and initial beside each policy, acknowledging you understand and agree.

_____ **MISSED APPOINTMENT POLICY:** A $50 fee applies to missed appointments without 24-hour notice. Cancellations or reschedules must be made by call or text—emails are not accepted. This fee is not covered by insurance.

_____ **INSURANCE:** You must show your current insurance at your appointment. We cannot correct claims later if your insurance is missing or invalid, whether it's your main or secondary coverage.

If your insurance does not process your claim, or reverses it for any reason, we are only able to re-submit claims within 90 days due to insurance company rules. If your appointment is older than 90 days, you will need to pay the standard self-pay office visit rate.

_____ **CARD-ON-FILE POLICY:** All accounts are required to have a valid credit card on file to cover fees, co-pays, co-insurance and deductibles. See separate form.

_____ **COLLECTIONS:** Unpaid balances aged five to nine months will be charged an 8% monthly late fee. After nine months, accounts are sent to a collection agency.

_____ **TRACTION ROOM POLICY:** The traction room is designated exclusively for patients aged 12 years and older. Individuals under the age of 12 are not permitted. To maintain a respectful environment, the space must remain quiet at all times. Please refrain from making phone calls, and ensure that device volumes are muted or use headphones as appropriate.

_____ **HIPAA**: I acknowledge that I have been advised that a full copy of this office's HIPAA Compliance Manual is available upon request. I consent to the use of my health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law and Federal Law.

_____

PRINTED NAME OF PATIENT

_____

MINOR(S)

_____ _____

SIGNATURE OF PATIENT TODAY'S DATE

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PERSONAL CONTACT INFORMATION

_____
EMAIL ADDRESS

_____ YES ____ NO_____
CELL PHONE NUMBER RECEIVE REMINDER TEXTS CIRCLE ONE

2026 EMERGENCY CONTACT PERSON

_____
EMERGENCY CONTACT #1 RELATIONSHIP PHONE NUMBER

_____
EMERGENCY CONTACT #2 RELATIONSHIP PHONE NUMBER

AUTHORIZED PEOPLE WHO HAVE ACCESS TO MY INFORMATION

I authorize Great Lakes Chiropractic of St. Michael to share my account information including TREATMENT DETAILS, ACCOUNT INFORMATION, PAYMENT DETAILS, AND APPOINTMENT TIMES with the following people. (spouse, parent, children)

_____ _____
NAME RELATIONSHIP TO PATEINT

_____ _____
NAME RELATIONSHIP TO PATEINT

_____ _____
NAME RELATIONSHIP TO PATEINT

☐ **Please do NOT allow anyone to access my information**

This is valid until revoked or changed by written communication.

_____ _____
SIGNATURE OF PATIENT (OR RESPONSIBLE PARTY, IF MINOR) TODAY'S DATE

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AUTHORIZED CARD-ON-FILE

I am providing Great Lakes Chiropractic of St. Michael with a credit card to be stored securely and used for all fees, co-pays, and/or co-insurance or deductibles after insurance has processed my claims. The card on file can be changed or removed at any time by contacting Great Lakes Chiropractic of St. Michael.

_____ The card-on-file will only be used in these situations:
(Initial)

a) **when authorized by you to pay your balance**
b) **automatically when you have a past due balance of over 60 days**
c) **automatically for a missed appointment fee**
d) **automatically when you cancel/reschedule an appointment with less than 24-hour notice**

I agree to respond promptly when Great Lakes Chiropractic of St. Michael notifies me that my card-on-file does not work or has expired.

This card-on-file can be used for the following people or family members:

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

This consent is valid from date I sign it until I notify Great Lakes Chiropractic in writing that it is no longer in effect.

_____ _____
SIGNATURE TODAY'S DATE

From Rectangle Health, the credit card processing software vendor:
"All cards are electronically stored and encrypted in the payment portal software, such that no direct staff at Great Lakes Chiropractic or support staff at Rectangle Health can view your information at any point, beyond the last 4 digits. Once imbedded into the software the information is encrypted and stored.

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CONSENT FOR EVALUATION AND TREATMENT OF A MINOR WITHOUT PARENT/LEGAL GUARDIAN PRESENT

USE FOR MINOR COMING ALONE (SIGNED IN ADVANCE)

I, _____ having legal custody of
Printed Name of Parent or Legal Guardian

of _____ whose birth date is _____,
Printed Name of Minor Date of Birth

give permission to Great Lakes Chiropractic of St. Michael to provide chiropractic care to my child while I am not present at the appointment.

I authorize Great Lakes Chiropractic to act on my behalf in case of an emergency. If this occurs, Great Lakes Chiropractic will make diligent efforts to notify me of the situation and obtain my preferences. If such efforts to contact me are unsuccessful, I authorize Great Lakes Chiropractic to take appropriate and necessary actions to care for my child. I also agree that I will be responsible for the charges that result from my child's care.

This consent is valid from date I sign this consent, until I either notify Great Lakes Chiropractic in writing that it is no longer in effect, or my child turns 18 years old, whichever occurs first.

_____

Signature of Parent or Legal Guardian Phone Number Date

USE FOR MINOR ACCOMPANIED BY ANOTHER ADULT (SIGNED IN ADVANCE)

I, _____ having legal custody of
Printed Name of Parent or Legal Guardian

of _____ whose birth date is _____,
Printed Name of Minor Date of Birth

authorize the caregiver(s) listed below to accompany my child to clinic appointments, receive my child's medical information, and consent to chiropractic care for my child.

_____ _____
Name of Caregiver (Print) Caregiver Phone Number

_____ _____
Name of Caregiver (Print) Caregiver Phone Number

This consent is valid from date I sign this consent, until I either notify Great Lakes Chiropractic in writing that it is no longer in effect, or my child turns 18 years old, whichever occurs first.

By signing this consent, I agree that Great Lakes Chiropractic may disclose health information about my child to the listed caregiver(s) for the timeframe I indicated above. I also agree that I will be responsible for the charges that result from my child's care. I understand that I may revoke this consent by sending a written request for cancellation to Great Lakes Chiropractic, and that the cancellation will take effect when the written request is received.

_____

Signature of Parent or Legal Guardian Phone Number Date