Authorization and Release

Patient Name: _____

I authorize the release of any information concerning my health and health care services, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care, to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me under any insurance or pre-paid health plan.

I understand that the benefits quoted by my insurance company are not a guarantee of payment and all charges are considered at the time claims are processed. I understand that my insurance carrier may pay less than the actual bill for services rendered. I agree to be responsible for payment of all services rendered on my behalf or my dependants. I agree to notify your office of any and all insurance changes that would affect the filing of claims or payment for the treatment I receive.

I understand that payment in full is due at the time of service unless other arrangements have been made.

Signature of patient or guardian _____ Date _____

Informed Consent for Treatment

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatment) and any other associated procedures that may include but not limited to physical examination, diagnostic testing and x-ray and physical therapy procedures.

I understand with chiropractic treatment, as well as any health care procedures, there are certain risks and complications associated with this type of treatment. Such complications include but are not limited to: post treatment soreness or discomfort, soft tissue injury, dislocation, and fractures. Although rare, some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications. I wish to rely upon the doctor to exercise judgment during the course of the treatment which the doctor feels at the time, based on the facts then known, are in my best interest.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. By signing below, I state that I have been informed and weighed the risks involved in chiropractic treatment. If you have any questions concerning the above, please ask your doctor of chiropractic.

Having carefully read the above, I give my informed consent to have chiropractic treatment administered.

Signature of patient or guardian _____ Date _____

HIPAA Privacy Practice Acknowledgement

I have received or was offered and declined a notice of privacy practices.

Signature of patient or guardian _____ Date _____

Consent to Treat a Minor (if applicable)

Having carefully read the above, as the parent or legal guardian of _____ I give my informed consent to allow chiropractic treatment to be administered to my child.

Signature of patient or guardian _____ Date _____