Name_____ **Date**_____ **File #**_____

Please read thoroughly, initial each applicable section and sign at the bottom. If you have any questions, please talk to your doctor. Thank You

Authorization to Release Information

_____ I authorize this health care facility to release all information related to the care I receive to my HMO, insurance company, third party payor or their designee. I understand that this may be necessary for the payment of my bill, determining benefits or for utilization and quality review purposes.

Information about Possible Risk of Chiropractic Treatment

_____ You have the right, as a patient, to be informed about your condition and the recommended integrative and complementary procedure to be used so that you make an informed decision whether or not to undergo the procedure after knowing the risks and hazard involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure. Doctors of chiropractic, Medical Doctors and Physical Therapists using manual therapy treatment for patients with headaches and cervical spine (neck) complaints are required to explain that there have been rare cases of injury to a vertebral artery as a result of treatment. Such an injury has been known to cause a stroke, sometimes with serious neurological damage. The rare chance of this happening is estimated to be approximately from 1 per 400,000 treatment to 1 per 10 million treatments. Appropriate tests will be performed to help identify if you may be susceptible to this type of injury; you will be notified if that is the case. If you have any questions about this, please do not hesitate to speak with your practitioner.

As with any health procedure, complications may arise during treatment. These complications include soreness, muscle or ligament strain, dislocations, fractures, disc injuries or physiotherapy burns. These are extremely rare occurrences.

Assignment of Benefits

_____ I assign all benefits payable to me for my care to Brook West Chiropractic Clinic. I understand that this health care facility will be paid directly by the insurance company or other payor. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

Guarantee of Payment

_____ I guarantee payment of all charges incurred for treatment in accordance with the rates and terms of this health care facility, despite insurance coverage or reimbursement.

Consent for Treatment

_____ I authorize the performance of diagnostic tests, procedures and treatment deemed necessary by personnel involved in my care.

Notice of Privacy Practices

_____ I acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Brook West Chiropractic Clinic, which describes the Practices' policies and policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

Authorization to Treat a Minor (under the age of 18)

_____I hereby request and authorize my doctor at this clinic to perform diagnostic tests and render chiropractic adjustment and other treatment to my minor son/daughter. As of this date, I have legal right to select and authorize health care services for the minor child named above. Under the terms and conditions of my divorce (if applicable), separation or other authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in anyway, I will immediately notify Brook West Chiropractic Clinic.

_____

Signature of Patient or Responsible Party Date Relationship to Patient

_____

Signature of Provider Date