Scherping Chiropractic PA

Patient Name: _____ DOB: _____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Initial _____ I request and consent to performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy on me or on the patient named above, for whom I have the legal right to select and authorize health care services, by the licensed doctors of chiropractic who now or in the future work at Scherping Chiropractic, P.A. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify Scherping Chiropractic PA.

I have had an opportunity to discuss with the doctor and/or with other office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand the results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes (CVA), and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which, will be based upon their knowledge and the facts given to them, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by initialing above I agree to the above –named procedures. I intend this consent form to cover the entire course of care of my present condition and for any future condition(s) for which I am seen for chiropractic care.

FINANCIAL POLICY OF SCHERPING CHIROPRACTIC PA

Initial_____ I clearly understand and agree that all services rendered to me are charged directly to me and I am responsible for all bills incurred at Scherping Chiropractic PA, whether or not paid by insurance.

Initial_____ I authorize the use of my signature below to allow the insurance companies to pay Scherping Chiropractic PA and authorize the doctor to release all information necessary to secure payment of benefits.

Initial_____ I understand that I may be charged $30 for any missed appointment that I schedule and do not cancel with at least two hours prior notice for doctor visits.

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

Initial _____ I am aware of Scherping Chiropractic PA Notice of Privacy Practices (a copy is available on our website at www.scherpingchiropractic.com or a copy will be provided to you upon your request).

Request for family member access to protected health information

I hereby grant permission for Scherping Chiropractic, P.A. doctors, staff or designees to discuss my care or any information in my medical chart including billing statements with the following person(s). I understand that this written notification is effective immediately and indefinitely and can only be revoked or changed by myself in writing. This is in accordance with HIPAA regulations.

Name of Person: _____ **Relationship _____**

Name of Person: _____ **Relationship _____**

None: _____ (initial)

I have read each section above and have completed/initialed each appropriate section.

_____ _____ Effective for one year
Signature of Patient Date

_____ _____ _____ Effective for one year
Signature of Parent/Representative (if applicable) Relationship Date