

**CHIROPRACTIC INFORMED CONSENT**

Please read thoroughly, initial at each section and sign at the bottom. Thank you.

**Authorization to Release Information** \_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize Acupuncture Works 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 hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so that you may give or withhold your consent to the procedure. In addition to spinal manipulation, treatment can also involve other forms of therapy including: electrical stimulation, hot and cold packs, infrared heat, manual and massage therapy, exercise, topical pain relieving gel, and nutritional supplements. As with any health procedure complication may arise during treatment. These complications include soreness, muscle or ligament strain, dislocation, fractures, stroke, disc injuries, or physiotherapy burns. These are extremely rare occurrences.

**Assignment of Benefits** \_\_\_\_\_\_\_\_\_\_\_\_

I assign all benefits payable to me for my care to Acupuncture Works. I understand this healthcare 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.

**Consent for Treatment** \_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Authorization to Treat a Minor** \_\_\_\_\_\_\_\_\_\_\_

I hereby request my doctor at this clinic to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter. This authorization also extends to all other doctors in this clinic and is intended to include radiographic examination at the doctor’s discretion. 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 any way, I will immediately notify Acupuncture Works.

Signature of Patient's or Responsible Party:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_