

PATIENT CONSENT

CONSENT FOR CARE

I voluntarily consent to the rendering of care, including chiropractic adjustments/entrainments and performance of analytic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

RELEASE OF INFORMATION

By signing this form, you are granting consent to Kingsbury Wellness Center to use and disclose your protected health information for the purposes of care, payment and health care operations. Our *Notice of Information Practices* provides more detailed information about how we may use and disclose this protected health information.

Our *Notice of Information Practices* is subject to change. If we change our *Notice*, you may obtain a copy of the revised *Notice* by telephoning our office at 732-563-6737. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of care, payment or health care operations. We are not required by law to grant your request; however, if we do decide to grant your request, we are bound by our agreement.

MEDICARE AND MEDICAID CONSENT TO RELEASE INFORMATION

I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim(s).

CONSENT TO OTHER OFFICE PROCEDURES/PRACTICES/POLICIES

Please initial if you consent to: _____ open/group room care _____ private room care
_____ testimonials _____ sharing your case information with staff, insurance companies,
and other health professionals _____ allowing others to observe you for educational
purposes

VERIFICATION OF NON-PREGNANCY (Female patients only)

By my signing on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.
Date of last menstrual period _____.

X _____ Date _____
Print Patient's Name

X _____
Patient's Signature

X _____
Other Than Patient, Print Name and Relationship

X _____ Date _____
Witness

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