

**PATIENT CONSENT FORM**

**PATIENT NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Please Print)

**Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, the patient above, and/or parent or guardian of the patient, voluntarily consent to such care encompassing diagnostic procedures and medical treatment provided by the chiropractic physician as is necessary in his/her professional judgment. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to mas as a result of examination or treatment in this facility.

\_\_\_\_\_\_\_ I hereby authorize the St. Croix Spinal Care & Sports Rehabilitation Center to release medical information regarding myself and my current condition to my insurance company for purposes of payment and/or quality reviews; and to referring, consulting treating physicians, or other medical providers as necessary to support continuation of care.

\_\_\_\_\_\_\_ I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. **I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. (NOT ALL SERVICES MAY BE COVERED BY MEDICARE, MEDICAID, AND FORWARD HEALTH. Some insurance companies may send payment directly to you, if you are not paying at the time of service it is your responsibility to sign over the payment from the insurance company to St. Croix Spinal Care & Sports Rehabilitation center for the treatment received.)** I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I also understand that I am responsible for any fees accrued if sent to collections. I also understand that this office has the reserved right to charge a fee for a **No Show** or **failure to cancel appointments.**

\_\_\_\_\_\_\_ I understand and agree to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. I understand that if I want a more detailed account of how my Patient Health Information is going to be used in this office and my rights concerning those records, I can request and obtain a copy of the HIPAA NOTICE that is available at the front desk. I understand that if there is anyone that I do not want to receive my medical records, I will inform the office.

I have read this for and understand its contents at this date and time.

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**PATIENT OR LEGAL REPRESENTATIVE LEGAL RELATIONSHIP**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DATE**