



Please read thoroughly, INITIAL at each section and SIGN at the bottom.

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, adjuster, attorney, 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 treatments 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, disk injuries or physiotherapy burns. These are extremely rare occurrences.

Assignment of Benefits

_____ I assign all benefits payable to me for my care to Uptown Natural Care Center. 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. I acknowledge that I will be responsible for the amount of any unpaid balance, with interest, as allowed by law.

Guarantee of Payment

_____ I guarantee payment of all charges incurred for treatment in accordance with the rates and terms of this health care facility.

Consent for Treatment

_____ I authorize the performance of diagnostic tests, procedures and treatment deemed necessary by personnel involved in my care. I understand that interns receiving chiropractic training may be involved in my care and that information about my case may be used in case presentation (my name and other personal information is kept confidential.)

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

_____ I hereby request and authorize my doctor/student intern at this clinic to perform diagnostic tests and render chiropractic adjustment and other treatment to my minor son/daughter. This authorization also extends to all other doctors and interns 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 Uptown Natural Care Center.

Signature of Patient or Responsible Party

Date

Relationship to Patient