

Consent to evaluate and adjust a minor child

I, _____, being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Signature

Date

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that an x-ray can be hazardous to an unborn child. Date of last menstrual period: _____

Signature

Date

Consent for Treatment

I, the undersigned, hereby authorize the Doctors of Porter Family Chiropractic and whomever they may designate as their assistant(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as is necessary.

I, also, certify that no guarantee or assurance has been made to the results that may be obtained.

I understand and agree that insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. **However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.**

Patient's Signature _____ Date ____/____/____ Witness _____

HIPPA INFORMATION

DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

1. I give permission to Porter Family Chiropractic use my address, phone number and clinical records to contact me with birthday cards, newsletters, patient letters, thank-you cards, first adjustment calls, testimonials and information about treatment alternatives or other health related information.
2. By signing this form you are giving Porter Family Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Haumesser Chiropractic. The written notice must contain the following information:

Your Name, Social Security Number and Date of Birth; A Clear Statement of Your Intent to Revoke This AUTHORIZATION; The Date of Your Request and Your Signature.

I have read and agree to the financial policy and Hipa privacy policy set above. Furthermore should I for any reason, discontinue care, I understand that the entire balance for professional services rendered to date will be due within 30 days. I agree that you may release my information to my insurance agent / adjuster or their agents regarding my care in this office. I also understand that the records including x-rays are a permanent record and are the property of Porter Family Chiropractic. Copies are available at a nominal charge. A copy of this agreement will serve as the original. This AUTHORIZATION is requested by Porter Family Chiropractic for its own use or disclosure of PHI. (Minimum necessary standards apply.) You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, Porter Family Chiropractic will not refuse to provide treatment.

Name (printed)

Date

Signature of Patient / Guardian

Witness

Your Family and Your Health are in Great Hands!