Chiropractic Works/Athens Brain Training Authorization and Consent Form

Patient Acknowledgement of Notice to Private Practices: As required by the privacy standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I have been offered an electronic copy of the Notice of Privacy Practices that describes how my identifiable information may be used and disclosed and how I can get access to my health information. I understand the Notice may be changed at any time as permitted by applicable law. I may obtain a current paper copy of the Notice by asking the front desk personnel for one, or I can view it via my electronic access to my electronic health record or the copy posted in the reception area.
Would you like a paper copy for your records? _____Yes _____No.
My signature below acknowledges that I have been provided access to an electronic copy and a paper copy posted in the reception area of the Notice of Privacy Practices to read.

Print patient name_____ DOB_____/_____/_____Today's Date_____

Signature of patient or legal representative_____ relationship to patient _____

Who can we release information to / speak to about your care?

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

Consent to Treat: I hereby authorize and consent to treatment-related health care services, including but not limited to: chiropractic adjustments, examinations, x-rays, and various modes of manual/physical therapies, stretching, massage, therapeutic ultrasound, electric muscle stimulation, hot or cold packs, traction, decompression, and exercise. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure, which the doctor feels, based upon the facts known, are in my best interest. I acknowledge that I have discussed, or had the opportunity to discuss, with either the doctor or staff, the risks and benefits of undergoing treatment; I have freely decided to undergo treatment, and hereby give my full consent to treatment. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Signature of patient or legal representative_____ relationship to patient _____Date _____

Consent for Minor: I acknowledge that I have read and understand the above consent to treat information and authorize and give consent to the doctor(s), staff, and doctor assistants of Chiropractic Works/Connect My Brain to treat my minor child. As of today's date, I have the legal right to select and authorize health care service for the minor child named below.
If applicable, under the terms and conditions of my divorce, separation or other legal authorization, the consent of spouse, former spouse or other parent is not required. If my authority to select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Print child's name_____ Relationship to child_____

Parent/Guardian Print & Sign name_____Date_____/_____/_____

Payment Policy Agreement abbreviated: I understand and agree that my health/accident insurance policies are an arrangement between my insurance carrier and myself. I understand and agree that I am personally responsible for payment of all services rendered to me, and minor if applicable. I also understand that if I suspend or terminate care, any fees for services rendered will be due immediately. I hereby acknowledge that I have read and understand the full payment policy of this office and agree to abide by its guidelines.
Would you like a paper copy of the full payment policy for your records? _____Yes _____No

Signature of patient or legal representative_____ relationship to patient _____Date_____

I understand that open room adjusting may be used and that if I wish to speak with the doctor or staff in private, I need to inform a staff member. Patient Initials _____

FOR OFFICE USE ONLY: To be completed only if Acknowledgement is not signed. Staff Initials_____ Date _____

Was the patient given a copy of Notice of Privacy Practices either/and in print/electronic format? [ ] YES [ ] NO
Please explain why the patient was unable/refused to sign and our efforts to try to obtain signature: