

Patient Name _____

Patient D.O.B. _____

NOTICE OF PATIENT PRIVACY RIGHTS

By signing below, I acknowledge that I have received a copy of the “Notice of Patient Privacy Rights” and a copy will be available for me at the reception desk upon my request. The Health Insurance Portability and Accountability Act (HIPPA) ensures a patient’s right to privacy regarding personal health information and it is this office’s policy to maintain confidentiality to the highest degree.

Patient/Legal Guardian Signature Date

Doctor’s Signature Date

OFFICE POLICIES

I agree to take full financial responsibility for my care in the event that the assumed coverage (Insurance, Worker’s Compensation, No Fault Insurance, etc) is denied for any reason. I further understand that the office charges a \$20 fee for returned checks. I also understand that some visits may be on a fee-for-service basis. Such fees and co-pays are to be collected upon arrival for appointment.

The office reserves the right to charge for appointments cancelled without 24 hours notice and for not attending scheduled appointments. MISSED APPOINTMENT FEE is \$40. Patients *late* for appointments have the option of either using the remainder of the time scheduled or the patient may reschedule the appointment and be charged for the missed visit.

Patient/Legal Guardian Signature Date

Doctor’s Signature Date

CONSENT TO TREATMENT

I hereby request and consent to the performance of chiropractic evaluation/care, manipulations, and/or any other chiropractic procedures by any licensed provider of Health in Focus, any future provider of Health in Focus, or any relief provider for my regular provider.

While Chiropractic examination and therapeutic procedures are usually considered to be remarkably safe and effective, occasionally there may be adverse reactions. Although the chances of experiencing any of these complications are extremely small, it is the practice of this office to fully inform and educate all of our patients. By signing below, I understand that these complications include, but are not limited to, allergic reactions, muscle soreness or bruising, muscle strain, sprains, fractures, dislocations, disc injuries, and strokes. I do not expect the provider to be able to anticipate or explain all possible risks and complications. I wish to rely on the provider to exercise judgment during the course of my treatments which they feel at the time, based upon the facts then known, is in my best interests. I intend this consent form to cover the entire course of treatment for present condition and future condition(s) that I may seek treatment for.

I understand that there is not guarantee or warranty for a specific cure or result. I understand that at any time, I can request further explanation regarding risks and benefits of care in this office, alternative courses of care, and the consequences of not having the proposed treatment. Further, I agree to notify the provider immediately with any concerns, if I were ever to become uncomfortable for any reason – treatment is too much to tolerate, personal issues with space or touch, religious, etc.

Patient/Legal Guardian Signature Date

Doctor’s Signature Date