

PRINT NAME: _____ FILE: _____

INFORMED CONSENT: CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (the patient named below, for whom I am legally responsible) by the doctors at Bak Chiropractic who now or in the future will be treating me in this office.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including but not limited to sprains and strains, fractures, disc injuries, strokes, dislocations and general aggravation of inflammatory conditions. I understand that I will have an opportunity to discuss with the doctor or other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that the doctor will perform an exam in order to minimize any risk of care, however, I do not expect the doctor to anticipate and explain all risks and complications. I therefore wish to rely on the doctor to exercise judgement during the course of the procedure, which the doctor feels at the time, based upon the facts as then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content and by signing below I agree to the procedures. I intend for this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

X _____
Patient Signature

Date

Parent or Legal Guardian (if patient is under 18 years of age)

Date

INSURANCE AUTHORIZATION FORM

I understand and agree that all fees for professional services rendered on my behalf are my personal responsibility and are due and payable at the time services are performed unless other arrangements are made. In the event that the insurance company should pay me for services due this office, I will immediately settle the outstanding bill with this office.

Signed:**X** _____

Date: _____

RELEASE OF MEDICAL INFORMATION

I hereby authorize and direct Jennifer J. Bak, D.C. P.C. d/b/a Bak Chiropractic Office to release all medical and financial information necessary to process this claim and to inform my Primary Care Physician or other physician should I need to be referred out for purposes of further evaluation or clinical information update.

Signed:**X** _____

Date: _____

AUTHORIZATION TO PAY

I hereby authorize and direct the immediate payment of said benefits directly to the Doctor and request and direct that my insurance company pay to said Doctor such sums as may be due to her upon receipt of an itemized statement for services rendered to me by the Doctor. I hereby authorize and direct my insurance carrier to pay all benefits, which may be due me according to my policy, directly to Bak Chiropractic Office to be applied to my account.

Signed:**X** _____

Date: _____