CRESTVIEW CHIROPRACTIC CLINIC **C/A_____**

PATIENT NAME:_____ Date:_____

Parent, Guardian or Patient's Legal Representative:_____

I. General Consent to Treatment

I authorize the rendering of such care, including diagnostic and therapeutic treatment by the physicians and staff of Crestview Chiropractic Clinic, as may be deemed necessary or beneficial. I understand that I have the right to make decisions concerning my health care, including the right to refuse any procedures. I understand that I may withdraw my consent for treatment at any time.

Patient / Guardian Signature:_____

II. PREGNANCY STATEMENT

Pregnant: NO _____ (neither confirmed nor suspected) YES_____ Delivery Date___/___/___

First Day of Last Menstrual Period___/___/___ Method of Birth Control_____

Patient Signature:_____

III. OFFICE POLICY CONCERNING MISSED APPOINTMENTS

Please arrive at least **10** minutes early to fill out any paperwork. If you are going to be late please call as soon as possible. If you are unable to make scheduled appointment, we request a **4** hour notice. Otherwise you may be charged ***$30 for a missed chiropractc appointment***; or ***$70 for a missed massage appointment***.

Patient / Guardian Signature:_____

IV. ADDITIONAL INFORMATION

Patient Address_____ E-mail_____

Phone: Home _____Work _____ Cell _____

Patient Employer: _____Spouse/Guardian Name:_____

Emergency Contact Name/Phone #: _____

V. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them. ***I understand that this form will be placed in my patient chart and maintained for six years.*** List below the names and relationship of people to whom you authorize the Practice to release personal health information to.

Spouse:_____ Physician(s):_____

Other:_____

Patient/Guardian Signature: _____

VI. INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any information required to process and bill my insurance. I authorize insurance payments to be sent directly to the Doctor.

Patient/Guardian Signature: _____