Union Square Chiropractic Consent To Services

PATIENT'S RIGHTS **Pt. Initials________**

Union Square Chiropractic respects the unique differences of our patients, and will ensure that health care ethics are maintained for all patients. The following rights will be exercised on our patients' behalf:

1. The patient has the right to considerate and respectful care.
2. The patient has the right to and is encouraged to obtain from the doctor relevant, current, and understandable information concerning diagnosis, treatment, and prognosis.
3. The patient has the right to know the identity of the doctor, staff, and all involved in patient care.
4. The patient has the right to make decisions about the plan of care prior to and during the course of treatment, and to refuse a recommended treatment or plan of care to the extent permitted by law, and to be informed of the consequences of this action.
5. The patient has the right to every consideration of privacy.
6. The patient has the right to expect that all communications and records pertaining to his/her care will be treated as confidential, except in cases where reporting is permitted or required by law.
7. The patient has the right to expect reasonable continuity of care when appropriate and to be informed by the doctor of available and realistic patient care options.

CONSENT TO TREATMENT OF A MINOR CHILD *(Under the age of 18)* **Pt. Initials________**

I authorize Ultra Sound, Electric Stimulation, Cold Laser, Chiropractic &/or Rehabilitation as deemed necessary to my _______________________(relationship).

FEMALE PATIENTS *(ONLY)* **Pt. Initials________**

This is to certify that, to the best of my knowledge, I am NOT pregnant and that USC has my permission to utilize Ultra Sound and prescribe x-rays.
Beginning date of last menstrual period _______________.

PAYMENT, INSURANCE, MEDICAL RECORDS, AND USE OF NAME (for treatment; if you take care) **Pt. Initials________**

I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.

I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum in now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

I understand and agree that health and accident 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 any amount authorized to be paid directly to this office will be credited to my account upon receipt. 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. I also understand that if I suspend or terminate my care and treatment, and fees for products or professional services rendered will be immediately due and payable.

CONSENT TO X-RAY ASSIGNMENT AGREEMENT **Pt. Initials________**

I consent to allow USC to use the services of an outside Radiologist if needed to insure the highest quality interpretation of my x-rays. I acknowledge that these services are separate from those of the clinic where I am receiving care, and that the charges for these services will be submitted to my insurance carrier, Workers' Compensation carrier of State Bureau, and/or to my attorney in the case of personal injury.

In the event that I receive payment for these services, I agree to promptly remit payment to the Radiologist or radiology service.

I assign my insurance benefits and rights to payment to the Radiologist to the extent of their charges, and authorize them, or their agents, to bill and release information to my insurance company, attorney, and/or any third-party payer. I authorize my treating physician, insurance company, attorney, and/or third-party payer to provide the Radiologist or their agents with any information concerning my claim, their services, and/or payment for the services provided.

CONSENT TO CHIROPRACTIC &/OR REHABILITATION SERVICES **Pt. Initials_________**

I hereby request and consent to comprehensive examinations (chiropractic &/or Rehabilitation orthopedic &/or neurological), chiropractic adjustments/treatments *(and other procedures including various modes of physiotherapy modalities)*, rehabilitation intervention *(including soft tissue mobilization, therapeutic exercises, stretching, posture and ergonomic training, and home exercise program)*, and nutritional counseling/advice by USC *(& its staff)*, who now or in the future treat me in this office. I have had an opportunity to discuss with the USC Staff the nature and the purpose of the treatment indicated. I understand that results are not guaranteed and am informed that, as in the practice of medicine, the practice of chiropractic and in the practice of rehabilitation there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor(s) to be able to anticipate and explain all risks and complications, and wish to rely on the doctor(s) to exercise judgment during the course of any procedure which the doctor(s) feels at the time is in my best interest. I have read, or have had read to me, the full above consent and have also had an opportunity to ask questions about its content and by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for any future conditions for which I seek treatment by USC and/or employed staff.

NO SHOW/CANCELLATION/LATE POLICY

USC has the right to charge a fee of $25.00 for appointments ($90.00 for massage appointments) not cancelled within 24 hours of scheduled time or not showing for scheduled appointment and payment will be due on next visit. If patients show up for appointments more than 15 minutes late we may re-schedule or full treatment may not be given.

Pt. Initials ________

By my signature below, I acknowledge that I have read, understand, and agree to the above provisions, and I assign my insurance benefits as described above.

PRINTED___________________________________ SIGNED____ DATE___________________