CHICAGO CHIROPRACTIC & SPORTS MEDICINE

## Informed Consent

I hereby request and consent to treatment by the chiropractic physician and give the doctor permission and authority to treat me in ways that are judged beneficial to me based on chiropractic test, diagnosis, and analysis. I understand that results are not guaranteed and I am aware that there are some risks to treatment.

It is the responsibility of the patient to disclose any underlying physical defects, illnesses, or deformities that may not otherwise come to the attention of the physician and that may render the patient susceptible to injury. The chiropractic physician will not provide treatment if he/she is made aware of adverse conditions as stated above.

My signature below certifies that I have read and understand the above information regarding informed consent.

## Release of Information and Assignment of Benefits

I give permission to Chicago Chiropractic to release information, written and verbal, contained in my medical record, and other related information, to my insurance company, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries as it relates to my treatment and/or payment for services provided.

I authorize Chicago Chiropractic to obtain medical records and/or professional information as it relates to my treatment and/or medical benefits.

I have insurance and/or employee health care benefits as stated on the patient information form. I authorize payments directly to Chicago Chiropractic of medical benefits and/or insurance reimbursement for services rendered.

This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. My signature below certifies that I have read and understand the above information regarding release of information and assignment of benefits.

## Notice of Privacy Practices

I have reviewed the notices of privacy practices (HIPAA). I will be given a copy of the privacy practices upon request.

I hereby consent to the use and disclosure of my personal health information for the purposes of treatment and payment.

## Communication Consent

I give Chicago Chiropractic consent to communicate with me regarding my appointments, health care, insurance, and balance due via the following methods:

Home phone
Cell phone
Email
Text (appointment reminders only)

I have read and understood the terms outlined above and consent to all necessary treatment as determined by Chicago Chiropractic & Sports Medicine.

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Signature of patient or responsible party Date