

Back On Track Chiropractic Clinic Authorization Form

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. I acknowledge that I have received the clinic's Notice of Privacy Practices for protected health information.

Print Patient's Name	Patient / Parent's Signature	Date
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I understand and agree that my health/accident insurance policies are an arrangement between my insurance carrier and myself. I understand that Back On Track Chiropractic Clinic will prepare any necessary reports/forms to assist me in making collection from the insurance company and that any amount authorized be paid directly to Back On Track Chiropractic Clinic will be credited to my account upon receipt. I authorize the release of any medical information necessary to process my insurance claim and request payment of insurance benefits be paid directly to Back On Track Chiropractic Clinic. I understand and agree that I am personally responsible for payment of all services rendered to me by this office. I also understand that if I suspend or terminate my care/treatment, any fees for services rendered me will be due immediately. It is understood and agreed the amount paid to Dr. Back On Track for x-rays, is for examination only and the x-rays will remain the property of this office.

_____ Patient Initials

I hereby authorize Dr. Back On Track and/or other clinic personnel to treat my condition as deemed appropriate through the use of chiropractic adjustments and therapy procedures. I understand that the incidence of complications associated with chiropractic care is very low; however, rarely could include fracture, sprain, disc injury, stroke, dislocation, and. I consent to receive chiropractic care from Back On Track Chiropractic Clinic.

_____ Patient Initials

I authorize and give consent to Dr. Back On Track and/or other clinic personnel to provide any treatment deemed necessary to my minor child.

Print Patient's Name	Patient / Parent's Signature	Date
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I authorize Back On Track Chiropractic Clinic to share my/my child's health information with my/my child's medical doctor,

Dr. _____

Physician's Name and Address	Patient Initials
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I understand that an open adjusting room is utilized in this clinic and that I may speak with the doctor or staff members in a private setting at any time by notifying a staff member. I authorize Back On Track Chiropractic Clinic to notify me via telephone, fax, postcard, letter, or e-mail for appointment reminders, announcements, etc... _____ Patient Initials