

INFORMED CONSENT TO EXAMINATION, CHIROPRACTIC ADJUSTMENTS, AND CARE

I hereby request and consent to the performance of Chiropractic adjustments and other Chiropractic procedures, including the various modes of physical therapy, examinations and diagnostic x-rays, on myself or _____(for whom I am legally responsible) by Dr. Robin D. Shampine, DC, and/or other licensed Doctors of Chiropractic who are now, or in the future treat me while employed by, working or associated with, or serving as back up for the doctors, including those who work at the Highlands Chiropractic Clinic or any other office or clinic.

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, fractures, disc injuries, sprains, dislocations, and stroke. I do expect the doctor to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of procedure which the doctor feels at that time, based upon the facts then known, is in my best interests.

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

To be completed by patient:

Patient's Name: _____

Patient's Signature: _____

Date: _____

To be completed by the patient's representative, if necessary, e.g. if the patient is a minor or physically or legally incapacitated:

Patient's Name: _____

Name of patient's representative: _____

Representative's Signature: _____

As: _____
(Relationship to Patient)

Date: _____

ASSIGNMENT AND RELEASE

I AM FINANCIALLY RESPONSIBLE FOR SERVICES NOT COVERED BY MY INSURANCE. I AUTHORIZE THE DOCTOR TO RELEASE ANY HEALTH INFORMATION REQUESTED TO PROCESS MY INSURANCE CLAIMS; AND THAT MY CLAIMS BE PAID TO THE DOCTOR. I UNDERSTAND THAT PAST DUE ACCOUNTS MAY BE SUBJECT TO A LATE CHARGE OR FINANCE CHARGE. **ALSO, ANY CHARGES ASSOCIATED WITH A COLLECTION AGENCY WILL BE MY RESPONSIBILITY.** I AM AWARE THAT THE DOCTORS ROUTINELY SEND X-RAYS OUT FOR SECOND OPINION CONSULTATION AND THAT I WILL BE FINANCIALLY RESPONSIBLE FOR THOSE SERVICES.

Patient's Signature

Date