**Consent to Treat**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including examination and physical therapy modalities on me (or the patient named below for who I am legally responsible) by Dr. Heather Cassese and/or any other licensed Doctor of Chiropractic who now or in the future render treatment to me while employed by, working in associate with, or serving as a fill-in doctor for Dr. Cassese.

I understand that, as with any health care procedure, there are certain complications that may arise during a chiropractic treatment. Those complications include, but are not limited to: fractures, dislocations, disc injury, muscle strains, and ligament sprains. Some types of manipulation of the neck have been associated with injuries to the arteries of the neck leading to or contributing to serious complications including stroke. I do not expect Dr. Cassese to be able to anticipate all risks and complications. I wish to rely on Dr. Cassese to exercise her best judgment during the course of the procedures which she feels at the time, based upon the facts then known, are in my best interests.

I have had the opportunity to discuss with Dr. Cassese and/or with office personnel the nature, purpose, and risks of chiropractic adjustments and procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read, or had read to me, the above explanation of the chiropractic adjustment and related procedures. I have weighed risks involved in undergoing treatment and have, myself, decided it is in my best interest to undergo the recommended chiropractic treatment. Having been informed of the risks, I hereby give my consent to treatment. I intend this consent to cover the entire course of treatment for my present condition and any future conditions for which I seek treatment.

**Financial Agreement Policy**

I agree that in return for services provided by Dr. Heather Cassese I will pay my account at the time services are rendered or I will make financial arrangements satisfactory to Back to Basics Chiropractic for payment. If payment is not received, Back to Basics reserves the right to refuse future appointments on delinquent accounts.

**No Insurance:** Dr. Cassese is not in network with any insurance company. Payment is expected on the day that services are rendered. Back to Basics accepts cash, check, or credit card. If you would like a superbill to file with an insurance company on your own, please advise us and one will be provided.

**Personal Injury Claims:** Patients involved in a personal injury claim, who are filing Med Pay or Liability, must sign a lien. No payments will be made at the time services are rendered, once a valid Med Pay or Liability claim number and contact information has been verified. Once Dr. Cassese has released you from care, all bills and records will be sent to the third party payer. Any charges not covered in the settlement may then be billed to the patient.

**Returned Checks:** There is a $25 fee for any checked returned by the bank for insufficient funds.

By signing below, you agree to all the terms and conditions contained herein.

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Patient/Legal Guardian Signature Date

**Consent for Use or Disclosure of Health Information**

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may need to disclose your health information:

* If it is necessary to refer you to another health care provider or hospital for the diagnosis, assessment, or treatment of your condition.
* If there is another party responsible for the payment of your services.
* If our practice needs to use it for quality control or other operational purposes.

We reserve the right to change our privacy practice, however, any changes we make to those practices we will notify you in writing when you come in for treatment or by mail.

You have the right to limit who receives your health information. You may request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place a restriction on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree to your restrictions, the restriction is binding on us.

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorizations a condition of obtaining insurance, the insurance company may have the right to your health information if they decide to contest any of your claims.

**Appointment Reminders**

We may need to use your name, address, phone, or email to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. By signing this form, you are giving us authorization to contact you with these reminders and information.

Information we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by federal privacy rules.

This notice is effective as of the date that appears next to your signature below.

I authorize you to disclose my health information in the manner described above.

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Patient Printed Name Date

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Patient/Legal Guardian Signature