REILLY
CHIROPRACTIC

Patient Name: _____

Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that as a patient of Reilly Chiropractic Health and Fitness, I am authorizing them to proceed with any treatment that they deem necessary.

Women Only:

To the best of my knowledge I **am / am NOT** pregnant and (**give my permission / don't give permission**) to x-ray me for diagnostic interpretation.
(Circle one above) *(Circle one above)*

Communications:

Patients may be contacted by mail, email or phone.

Email: _____

If you would like to authorize Reilly Chiropractic to communicate your healthcare information with any individual(s) please list below:

Name _____ Relationship to you_____ Phone: _____

Name _____ Relationship to you_____ Phone: _____

No one: ____

Acknowledgement

Important Please Read

I authorize Reilly Chiropractic Physicians to release any medical information necessary to bill my account to my insurance company or its authorized representative, Workers Compensation or attorney. I authorize payment of my medical benefits directly to Reilly Chiropractic Physicians. I understand that I am financially responsible for charges not covered by this authorization.

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) posted on the wall, and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Signature: _____ Date: _____