GROSKOPP CHIROPRACTIC

Acknowledgements

To set clear expectations, improve communication and help you get the best results in the shortest amount of time, please read each statement. Your signature at the bottom of this form acknowledges your agreement.

I authorize the chiropractor to deliver care that, in his or her professional judgement, can best help in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity. I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely but not limited to fractures, strokes, and strains/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

- I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

- I grant permission to be called, texted, and/or emailed to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, or health information to me as an extension of my care in this office.

- I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

- To the best of my ability, the information I supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

FEMALE PATIENTS: I realize that an x-ray examination may be hazardous to an unborn child and will let the doctors know if I believe that I may be pregnant.

CONSENT TO TREAT A MINOR: I (we) being the parent, guardian or custodian of the minor being_____, age_____, do hereby authorize, request & direct Groskopp Chiropractic, it's doctors and staff to perform examinations, diagnostic x-rays, laboratory tests, an any treatment that in their judgment, is deemed advisable or required.

It is the understanding of the undersigned that the physicians and staff will have full authority from me as legal parent/guardian to continue with examinations, diagnostic tests, and treatments as will be needed while said minor shown above is under care in this office until legal age is attained.

As legal parent/guardian, I realize full responsibility for all charges and payments due.

Patient/Parent/Guardian or Custodian Signature: _____Date: _____