ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Advanced Chiropractic, which describes the practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the practice. I also authorize Advanced Chiropractic to send correspondence by either US Postal Service or email, if available.

Signature_____Date_____

Printed Name_____

CONSENT OF TREATMENT AND/OR PREGANCY RELEASE

I hereby authorize Advanced Chiropractic Associates and whomever the clinician may designate as his/her assistants to take X-rays, and release Advanced Chiropractic from any and all liability.

Signature_____Witness(staff use)_____

CONSENT OF TREATMENT OF MINOR/CHILD

I (we) being the parents, guardian or custodian of the minor being _____, age _____, do hereby authorize, request and direct the doctor's office as shown above, it's doctor and staff to perform examinations, diagnostic x-rays and any treatment that in their judgement, is deemed advisable or required. It is the understanding of the undersigned that the physicians and their 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 the office until legal age is attained.

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

Signature_____Witness(staff use)_____

Parent/Guardian

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I authorize the use of my signature on all insurance submissions. I understand that, should I not meet my payment responsibilities, I am fully responsible for all collection fees, travel expenses, interest charges, filing fees, court costs and attorney fees associated with the collection(s) of any of my outstanding debt.

Signature_____Date_____