By initialing and signing this form you acknowledge that you have read and understand the following.

HIPAA ACKNOWLEDGEMENT AND CONCENT

_____ I, the undersigned, acknowledge that I have had access to a copy of the NOTICE OF PRIVACY PRACTICES. I consent to your disclosure, which you deem necessary in connection with my or my child's condition. This information will only be distributed to your third party payer for purposes of reimbursement for services provided, and only upon direct request of your third party payer.

AUTHORIZATION AND ASSIGNMENT

_____ **AUTHORIZATION TO RELAESE INFORMATION** (if applicable): You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster, in order to process any claim for reimbursement for charges incurred by me as a result of professional services rendered by you of any consequences thereof.

_____ **ASSIGNMENT OF PAYMENT (**if applicable): My attorney and/or insurance company are hereby requested to pay direct to the doctor listed below, any moneys due him/her on account, the same to be deducted from any settlement made on me behalf. Further, I agree to pay the difference if any, between to total amounts of his/her charges and the amounts paid him/her by the attorney and/or insurance company. It is further understood that I, the undersigned, agree to pay the full amount of his or her charges, should my condition be such that it is not covered by my policy if for any reason the insurance company and/or attorney refuses to pay my claim. Accepting assignment does not release the patient from the responsibility for their yearly deductible or for their co-payment on services provided by the clinic. If you receive payment from your insurance carrier during the period which the clinic has accepted assignment of benefits, you are to bring to check into this office within one week of receipt and endorse it over to the clinic. Failure to do so will result in collection action.

_____ **MEDICARE ASSIGNMENT** (if applicable): I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration to its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

CONSENT TO TREAT

THIS CONSTITUES INFORMED CONSENT FOR MEDICAL, PHYSICAL THERAPY, AND/OR CHIROPRACTIC CARE.

_____ I hereby request and consent to the performance of specific testing and procedures on me (or the patient named below for which I am legally responsible) as deemed necessary by the providing physicians at Calzaretto Chiropractic Center LLC. I understand and am informed that, while extremely rare, there are some risks to treatment including, but not limited to: fractures, disc injuries, strokes, dislocations, sprains, and stains. I wish to rely on the doctor and treating provider to exercise judgment during the course of the procedures, based on the facts then known is in my best interest. I have read, or have had read to me, the above consent. I have the opportunity to discuss the nature and purpose of the chiropractic adjustment and other procedures with the doctor and/or office personnel. I agree to those procedures and intend this consent form to cover the entire course of treatment and for any future condition(s) for which I seek treatment

Patient Signature _____ _____Date _____