ASSIGNMENT OF BENEFITS: I authorize my or my child's physician to release information from my or my child's medical record to my or my child's insurance carrier(s), or government agency for the processing of claims for medical benefits applicable to the services and pay all assigned insurance benefits directly to my or my child's physician, on my behalf.

INITIALS: _____

CONSENT FOR TREATMENT: I voluntarily consent to my or my child's treatment; including physician examinations, all procedures and tests such as x-rays, and medical treatment by the staff of Shaw Chiropractic, PC. No guarantees have been made to the patient regarding the results of such care and treatments which are hereby authorized.

INITIALS:_____

PATIENT FINANCIAL POLICY: I understand all accounts are the full responsibility of the patient and/or the patient's responsibility party/guarantor. Please remember – your medical insurance policy is a contract between you and your insurance company. We cannot be a party to that contract. Due to the policy between patient and insurance company, all copays are due at the time of service.

INITIALS: _____

PRIVACY PRACTICES (HIPAA): I acknowledge that I have been offered a copy of Shaw Chiropractic, PC's Notice of Privacy

Practices. Accepted ____ Declined ____

RELEASE OF INFORMATION: I give my consent and authorization for the medical or billing staff of Shaw Chiropractic, PC to leave protected health care information about me or my child on my answering machine or voicemail via the telephone number I have listed below. I also consent to receive calls via

Check all that apply: phone___ voicemail___ text message___ email___

NUMBER _____ INITIALS ____

AUTHORIZATION TO TREAT A MINOR: I give consent to treat my minor child without a legal guardian present.

Accepted ____ Declined ____

PROTECTED INFORMATION:
My protected health information regarding me or my child may be shared with the following individuals:
NAME _____RELATIONSHIP _____
NAME _____RELATIONSHIP _____
NAME _____RELATIONSHIP _____

PRIMARY CARE PHYSICIAN:
NAME _____NUMBER _____

SIGNATURE: _____ DATE: _____

PRINTED NAME: _____ RELATIONSHIP TO PATIENT:_____