CONSENT FOR TREATMENT

RESULTS CHIROPRACTIC

I, _____, authorize and request that Results Chiropractic provide treatment, and/or diagnostic procedures which now or during the course of my care as a patient are advisable. The frequency and type of treatment will be decided between my doctor and me.

I understand that the purpose of these procedures will be explained to me and subject to my verbal agreement. I also understand that Results Chiropractic clinicians do not offer to diagnose or treat any disease. Only diagnosis that are either vertebral subluxation or neuro-musculoskeletal are offered. If, during the course of chiropractic spinal examination, a non-chiropractic or unusual finding is discovered, I will be advised accordingly. If I desire advice, diagnosis, or treatment for those findings, I will seek the services of another health care provider.

I understand that there is an expectation that I will benefit from chiropractic treatment but there is no guarantee that this will occur. I understand that the ONLY PRACTIC OBJECTIVE is to eliminate a major interference to the expression of the innate wisdom of the body.

I understand that not all practitioners within Results Chiropractic are licensed practitioners. All un-licensed practitioners are registered with the appropriate governing boards and practice under the scope of Dr. Mashike's license (DC 25982).

I understand that maximum benefit will occur with consistent attendance and that at times I may feel conflicted about my treatment as the process can sometimes be uncomfortable.

I have read and fully understand this Consent for Treatment form.

Name: _____ Signature: _____ Date: _____

RELEASE OF INFORMATION- INSURANCE

I consent to the release of information to my health plan for eligibility, claims, certification/ case management/quality improvement, and other health plan purposes.

Name: _____ Signature: _____ Date: _____

AUTHORIZATION TO LEAVE MESSAGES

From time to time, it is necessary for representatives of Results Chiropractic to leave messages for patients. The purpose of these messages is to remind patients of their appointments or to ask a patient to call Results Chiropractic. The purpose of this consent is to authorize us to leave messages with members of your household or on your answering machine.

Name: _____ Signature: _____ Date: _____

ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY STATEMENT

I acknowledge that I have received and read my information privacy rights within the HIPAA Notice of Privacy Practices provided to me.

Name: _____ Signature: _____ Date: _____