

People go to chiropractors for a variety of reasons. Some simply go for short term pain relief, while others are interested in long term correction of their spine-related problems. Please check the type of care you desire so that we may be guided by your wishes.

Temporary Relief Care: Short term care that helps relieve your current symptoms with the likelihood of their eventual return. The underlying spinal problem remains at the end of treatment. This type of care is short-term.

Corrective Care: While relieving your current complaints, it corrects the underlying spinal problems. This type of care is long-term.

PERSONAL MEDICAL INFORMATION CONSENT FOR MESTDAGH CHIROPRACTIC CLINIC

The Health Insurance Portability Accountability Act of 1996 (HIPAA) requires that we receive your permission before we use the personal information in your medical records for any reason.

This consent form gives us permission to use your Protected Health Information (PHI) to carry out treatment, receive and/or as part of health care operations of our practice. HIPAA also requires us to have a written notice of our privacy policy describing how medical information about you may be used and disclosed. If you so desire, this written notice is available at the front desk for you to read.

You have the right to revoke, in writing, this consent form at any time, although any services performed prior to the revocation of this consent are covered by this consent.

* **Patient or Guardian's Signature: X** _____ **Date:** _____

Restrictions:

Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our office's policies and practices may be required by changes in federal and state laws and regulations. Upon receipt, we will provide you with the most recent notice on an office visit. The revised policies and practices will be applied to all protected health information we maintain.

Doctor/Staff Signature: X _____ **Date:** _____

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays by Dr. Mestdagh and/or any other licensed Doctor of Chiropractic who now or in the future treats me while employed by, working or associated with or serving as back-up for Dr. Mestdagh. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feel at the time, based on the facts then known, is in my best interest. I have read this consent and my signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

* **Patient or Guardian's Signature: X** _____ **Date:** _____

INSURANCE ASSIGNMENT OF BENEFITS - Read & Sign if you believe you have chiropractic insurance benefits.

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to Mestdagh Chiropractic Clinic at 1550 N. Main Street, Unit A, Columbia, IL 62236. If my current policy prohibits direct payment to the doctor, then I hereby also direct you to make out the check to Mestdagh Chiropractic and mail it C/O Mestdagh Chiropractic Clinic at 1550 N. Main Street, Unit A, Columbia, IL 62236. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agree to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved with this case.

* **Patient or Guardian's Signature: X** _____ **Date:** _____

FEMALE PATIENTS ONLY - Non-Pregnancy Verification for X-rays

Let it be known by all people by my signature that I am not pregnant. If it later becomes known that I was pregnant during this x-ray examination, that I do not hold Mestdagh Chiropractic Clinic and/or Laurie Mestdagh, DC liable.

Patient or Guardian's Signature: X _____ **Date:** _____

CHILDREN & MINORS ONLY - Consent to Treat a Minor (completed by parent or guardian)

I hereby authorize the doctor and whomever he may designate as assistants to examine and administer chiropractic care as deemed necessary to my child.

Parent or Guardian's Signature: X _____ **Date:** _____