AUTHORIZATION FOR CHIROPRACTIC TREATMENT:

I hereby authorize Dr. Hein and the staff of Boulevard Chiropractic to perform diagnostic tests and render care considered therapeutically necessary on the basis of findings during the course of my treatment. As of the date stated below, I have the legal right to select and authorize health care services for the patient named above. If my authority to select and authorize this care should be revoked or modified in any way, I will immediately notify Boulevard Chiropractic. I understand that there is a minimal degree of risk that can occur with chiropractic care, and to decrease and/or prevent that risk Dr. Hein will administer a full health history and exam at my first visit to fully assess my current physical condition and determine the safest course of treatment.

I hereby certify that I have read and fully understand the above Authorization for Treatment. I can also certify that no guarantee or assurance has been made as to the results that may be attained.

Patient Name (PRINT):_____**Date:**_____

If other than Patient, Guardian Name (PRINT):_____

Patient or Guardian Signature:_____**Relationship:**_____

ASSIGNMENT AND RELEASE:

I, the undersigned, assign directly to Dr. Hein any medical benefits, if any, otherwise payable to me for the services rendered. I understand I am FULLY FINANCIALLY responsible for all charges whether or not covered by insurance. I hereby authorize the use of this signature on all my insurance submissions whether manual or electronic. Furthermore, I authorize the release of my medical records to secure payment and/or to receive medical information pertaining to my case in this facility.

Signature of Insured/Responsible Party: **Date:**

_____ _____

HIPAA PRIVACY STATEMENT:

In general, the HIPAA privacy rule gives individuals the right to request confidential communications or that a communication of private health information be made by alternative means, such as sending correspondence to the patient's office instead of home. Occasionally our office will send out greeting cards, reminder postcards, call you regarding an appointment, etc. Please let us know what forms of communication you would prefer to be contacted by. By signing this form, I am acknowledging that I have been notified of the Privacy Practices utilized in this office and have received a copy. I may be contacted in the following manner (please check ALL that apply):

Home Telephone: _____

( ) OK to leave a message with detailed information
( ) Leave a message with call-back number only
( ) Do not call my home

Work Telephone: _____

( ) OK to leave a message with detailed information
( ) Leave a message with call-back number only
( ) Do not call my work

Cell Phone: _____

( ) OK to leave a message with detailed information
( ) Leave a message with call-back number only
( ) Do not call my cell phone

Written Communication:

( ) OK to mail my home address
( ) OK to mail my work/office address
( ) OK to fax this number_____
( ) OK to email to _____

OTHER NOTES:_____
_____
_____

Patient Name (PRINT):

_____

If Parent or Guardian (PRINT):

_____

Patient Signature:

_____

Parent or Guardian Signature:

_____

Witness Signature:_____ **Date:**_____

****OFFICE USE ONLY****

___Copy of Ins. Card Updated Information: ___TC ___COMP ___FOLDER ___FAMILY

___Benefits Checked ___Updated in COMP ___TC ___Folder ___Family