

Patient Consent Forms

Consent to Examination and Treatment

I give the staff and doctor of Elledge Chiropractic Clinic permission to perform all examinations, test, and treatments, and anything else deemed necessary or beneficial to my care. I also understand the these actions will be performed by the doctor or staff member of the clinic. I further understand that I am ultimately responsible for payment of all services covered or non-covered, and I understand that all insurance payments paid directly to the clinic will be credited to my account.

Signature of Patient: _____

Date: ___/___/___

Signature of Guardian(If a minor): _____

Consent to Retrieve Medical Records

I give the staff and doctor of Elledge Chiropractic Clinic permission to collect and all medical records deemed necessary to assist with my care. This includes records from hospitals or any other provider of services which would be helpful in assisting in my treatment.

Signature of Patient: _____

Date: ___/___/___

Signature of Guardian(If a minor): _____

Verification of Non-Pregnancy

By my signature below, I do hereby state that to the best of my knowledge. I am not pregnant nor is pregnancy suspected at this time.

Signature of Patient: _____

Date: ___/___/___

Acknowledgement of Receipt of Patient Notice

By signing below, I acknowledge that I have received a copy of the Patients Privacy Notice (HIPPA) of Elledge Chiropractic Clinic, in force as of July,10 2006.

Patients Name: _____

Patients Signature: _____

Date Signed: _____

Witness(Office Staff): _____