Barneveld Family Chiropractic, LLC

Dr. Kimberly Horsfall, D.C.

Consent for Use or Disclosure of Health Information/Notice of Privacy Practices

I have read your "Notice of Privacy Practices" and agree to its terms. I am also acknowledging that I have been offered and/or received a copy of the "Notice of Privacy Practices".

Marketing Authorization

Barneveld Family Chiropractic, LLC is specifically requesting authorization to share the following with you and others.

Periodically, we produce newsletters, offer special promotions and develop special events for educational purposes. In addition we may send you a thank you for a patient referral, a birthday card, celebration of a birth or special accomplishment. Some or all of these occasions may also be posted on our bulletin board accompanied by a picture.

Billing Authorization & Release

I understand and agree all services and or charges rendered to me are ultimately my responsibility. Furthermore any service or charges not covered by insurance are required to be paid at the time the service or charge is incurred. Non-insured patients can be charged a monthly statement fee in the event there is a balance on their account at the end of the month. I further agree that the authorization and release is irrevocable and ongoing until all monies owed are paid in full.

I authorize the release of any medical or other information necessary to process any claim for reimbursement of charges incurred. I also authorize the direct payment of any medical benefits from an insurance company to Barneveld Family Chiropractic, LLC on my behalf.

I understand that outstanding accounts with a past due balance of 120 days or more will be sent to collections. in addition you will be charged 1% interest per month with a 12% total annual interest rate.

I also understand that if I am not able to cancel a previously scheduled appointment within 4 hours of the scheduled time or do not show up for said appointment that Barneveld Family Chiropractic, LLC will assess a pre-determined charge to my account.

This authorization and release will be in continual effect until revoked by both parties, in writing.

Informed Consent to Treat

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, on me by Dr. Kimberly Horsfall, D.C. and/or other licensed doctors of chiropractic who now or in the future work at Barneveld Family Chiropractic, LLC.

I have had an opportunity to discuss with Dr. Kimberly Horsfall, D.C. and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

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 I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I acknowledge receipt of a copy of the Privacy Practice Notice, Marketing Authorization, Billing Authorization & Release, and Informed Consent to Treat, and I understand and agree to its terms. I have also had an opportunity to ask questions about its content, and by 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.

_____

Print Patient Name

_____ _____

Signature of Patient or Personal Representative **Effective Date**

Consent for Treatment of Minor (If applicable)

I, being the parent, guardian or custodian of _____ , a minor, the age of _____, do hereby authorize, request and direct Dr. Kimberly Horsfall to perform, in her judgment, any necessary examination, X-ray, and chiropractic treatment for the condition.

_____

Print Parent or Guardian name

_____

Signature of Parent, Guardian or Custodian **Effective Date**

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