

**INFORMED CONSENT TO CHIROPRACTIC CARE**

**Patient:** Please discuss any questions or concerns you may have, in regards to this consent, with the doctor before signing this informed consent. *I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various models of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by this office.*

**Patient Signature: X** \_\_\_\_\_ **Date:** \_\_\_\_\_

Parent/Guardian Signature: X \_\_\_\_\_

(If patient is a minor)

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**PREGNANCY DISCLAIMER**

This certifies that concerns regarding pregnancy and radiation exposure have been explained to my satisfaction. *I understand the clinical necessity of having X-rays taken at this time and grant permission for this procedure. In so doing, I release the doctor/clinic from responsibility for potential damage arising from this procedure.*

**At the present time,**

\_\_\_\_\_ **I am sure that I am not pregnant**      \_\_\_\_\_ **I could be pregnant**      \_\_\_\_\_ **I am pregnant**

**Patient Signature: X** \_\_\_\_\_ **Date:** \_\_\_\_\_

Parent / Guardian Signature: X \_\_\_\_\_

(If patient is a minor)

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**ASSIGNMENT OF BENEFITS for Cook Chiropractic & Rehabilitation**

*In consideration of your undertaking to render care, I agree to the following: **Release of Information***

- 1.) You are authorized to release any information you deem appropriate concerning my physical condition, any insurance company, attorney of adjuster in order to process any claim for reimbursement of charges by me at your treatment facility*
- 2.) I authorize and assign to you, the medical provider, the right to receive direct payment from my attorney or any insurance company who may become obligated to pay me any sums. I further authorize the endorsement of my name to any draft containing my name which you are legally entitled.*
- 3.) In the event any insurance company or attorney, obligated by contractual agreement to make payments, me for your service charges, refuses to make such payment upon demand by you, I hereby assign you to prosecute said action either in my name or you name as you otherwise resolve said claim as you see fit, I understand that whatever amounts you do not collect from said insurance proceeds (whether it be all or part what is due) shall be paid by me.*
- 4.) I also assign to you, the medical provider, and grant the right to lien against many and all claims again any third party whose negligence may have caused my injury, including their insurance, up to the amount of bill for treatment.*
- 5.) I waive the Statue if Limitations regarding my doctor's rights to recover from me directly.*

**Patient Signature: X** \_\_\_\_\_ **Date:** \_\_\_\_\_

Parent/Guardian Signature (if patient is a minor): X \_\_\_\_\_