Grady Family Chiropractic, PC
26 W Dry Creek Cir
Suite 600
Littleton CO 80120

w: (720) 523-1293
f: (720) 523-1296
info@gradyfamilychiropractic.com
www.gradyfamilychiropractic.com

Patient: _____ DOB: _____ Date: _____

CONSENT FOR CHIROPRACTIC SERVICES

By reading below I have been made aware that:

1. The process of delivering a "Chiropractic Adjustment" (manipulation) may be performed manually or with an instrument to the vertebra(e) of the spine and/or associated structures (legs, arms etc.), often resulting in an audible pop or click sound;
2. As an addition to the Chiropractic Adjustment "Supportive Therapies and/or Procedures" may be applied by the chiropractor or by staff under the chiropractor's direction or supervision incorporating the use of Acu Tacs, electricity, traction, motion, bracing, nutritional advice, heat, or cold;
3. On occasion some temporary soreness and/or stiffness may occur; less frequently aggravation of presenting symptoms or initiation of new symptoms; rarely bruising, swelling, even more rare separation/fracture; and extremely rare, nerve or vascular injury may occur in conjunction with the process of a Chiropractic Adjustment;
4. The chiropractor has made no guarantee of a positive outcome from treatment.

Additionally:

1. I have been afforded ample opportunity for questions and answers.

Therefore by signing below:

I consent to the performance of the diagnostic and therapeutic procedures performed by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case.

I consent to the performance of other diagnostic and therapeutic procedures in the future that may be deemed reasonable and necessary by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case.

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

Signature of Patient/Parent or Guardian: _____

Signature of Witness: _____

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TERMS OF ACCEPTANCE

Patient: _____ DOB: _____ Date: _____

Before this office begins any health care operations we require you to read and sign this form stating that you understand the terms of acceptance as a patient. If you refuse to sign this terms of acceptance form the doctor reserves the right to refuse care.

AUTHORIZATION: By signing below you authorized this office/provider to complete a consultation and examination on the above named patient.

AUTHORIZATION FOR X-RAY WITH RELEASE: By signing below you have declared, to the best of your knowledge, that a) there is no chance you are pregnant at this time, b) you have no known limitations that would be a contraindication for an x-ray evaluation, and c) you consent to the taking of x-rays if there is a determined need.

ACKNOWLEDGMENT OF ASSIGNMENT OF BENEFITS: By signing below you acknowledge that a) you are fully responsible for all services rendered, b) you understand that your health and accident insurance policies are an arrangement between you and your carrier and that you may be required to pay some or all of the fees charged to your account, c) you hereby assign benefits to be paid directly to this office/provider by your third-party payer (e.g. insurance company, attorneys, etc.), and d) you acknowledge that this is a non-rescindable agreement and failure to fulfill this obligation will be considered a breach of contract between you and this office.

CMS-1500 HEALTH INSURANCE CLAIM FORM: By signing below you acknowledge and agree that the CMS-1500 Health Insurance Claim Form Box 12 and Box 13 will state "Signature on File." Box 12 Reads as follows: "PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below." Box 13 Reads as follows: "INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below."

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: We are very concerned with protecting your personal health information. There may be times our office may need to contact you regarding office matters. By signing below you have authorized this office to contact you for office related matters in the following manner: phone (work, home or mobile), e-mail and regular mail. Messages may be left on an answering device/voicemail, or with the person answering your phone (work, home or mobile). Also in accordance with the Health Insurance Portability and Accountability act of 1996 (HIPAA), updated September 23, 2013, this office is obliged to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient. By signing below you have acknowledged that you have been offered a copy of this document.

ACKNOWLEDGEMENT OF TREATMENT PLAN: By signing below I acknowledge that, if accepted for care, I may be presented with a chiropractic treatment plan resulting in one or more of the following services: chiropractic adjustments, examinations, and supportive therapies and procedures.

ACKNOWLEDGEMENT: By signing below you acknowledge that you understand and agree with the policies and procedures outlined in this TERMS of ACCEPTANCE form and certify that all the information given to the office/provider in the INTAKE forms are true and accurate to the best of your knowledge.

Signature of Patient/Parent or Guardian: _____