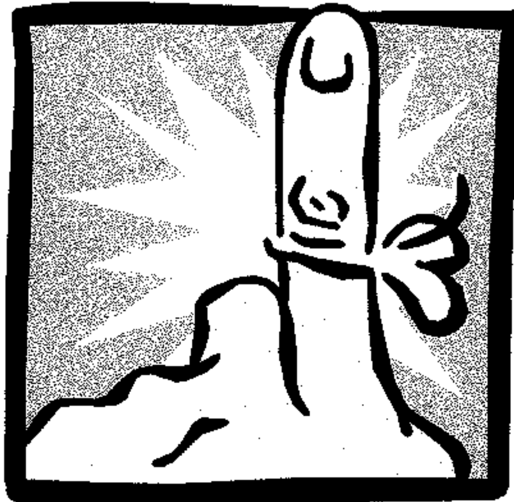

ATTENTION
MASSAGE PATIENTS:

Our office understands that schedules change and emergencies occur and we are happy to work with you as much as possible when scheduling appointment times for you.
It is office policy to charge a $25 fee when missing or cancelling an appointment for massage or muscular development and rehabilitation less than 24 hours from the scheduled appointment
This is due to our increase in patients wanting to schedule and keep appointments for massage or muscular development/rehabilitation and out of our consideration of our massage therapists. Appointments are made to reserve your time with our therapists. As a courtesy, they need to be kept or rescheduled in a timely manner.

Patient Name: ______________________

Patient Signature: ______________________

Date Signed: ______________________

Witness: __________________________

ASSIGNMENT OF BENEFITS TO

BELLEVIEW CHIROPRACTIC CLINIC

The undersigned hereby assigns the benefits of insurance available under any applicable insurance policy including, but not limited to, Personal Injury Protection (PIP) benefits, to Belleview Chiropractic Clinic, in exchange for the medical treatment and/or medical services rendered to the undersigned by Belleview Chiropractic Clinic.

Dated this __________ day of ____________________, 20_____.

____

PATIENT/INSURED

Belleview Chiropractic Clinic
10341 US Hwy 441
Belleview, FL 34420
352-245-0145

Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me (or on the patient named listed on this form for whom I am legally responsible), by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician. I further understand that such chiropractic services may be performed by the Physician of Chiropractic named here. **Dr. Dennis R .Seese** and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office.

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, and others, may also be used.

Possible Risks: I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications. In the rare event there are specific risks pertaining to my individual case, the doctor will address these with me directly.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have read or had read to me the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I intend to receive the recommended treatment and herby give my full consent to treatment.

To be completed by the patient's representative if necessary (if the patient is a minor or is physically or mentally incapacitated)

______________________	______________________	__________
Patient Name	**Signature**	**Date**

______________________	______________________	__________
Printed Name of Guardian Or Representative	**Signature**	**Date**

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Belleview Chiropractic Clinic
10341 US Hwy 441
Belleview, FL 34420
352-245-0145

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

By checking the lines below I authorize being contacted for practice reminders or birthday greetings by:

Mail _______;
Email_______;
Telephone ____;
By voice mail ________;

List below the names and relationship of people to whom you authorize the Practice to release PHI.

______________________________ ______________________________

______________________________ ______________________________

___________________________________ ___________________
Print Name (Patient /Guardian) Date

____
Signature (Patient /Guardian)

____
Witness

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS
(Rev. 11/16)