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AUTHORIZATIONS & ACKNOWLEDGEMENTS

While it is never our intention to bring anything of a potentially negative bent into a health and healing relationship, we, along with other health care providers and hospitals, are obliged by the state of New York to ask that you read and sign the following:

TREATMENT AUTHORIZATION: I (print name) _____ authorize Chiropractic Care, including spinal adjustment, of myself or my minor child by the Doctors and staff at Scott J Banks, DC, PC

INFORMED CONSENT: Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be an effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

PRIOR CHIROPRACTIC TREATMENT INFORMATION

Name of Chiropractor:_____ Location (city): _____

When was your last treatment?_____ Have you had x-rays taken?_____

MEDICAL DOCTOR: Scott J Banks, DC, PC believes your medical doctor is a vital part of your healthcare team. As such, upon your request, we will send evaluations and progress reports to the physician listed below.

NAME: _____ **SPECIALTY:**_____

ADDRESS:_____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

TELEPHONE: _____ **FAX:** _____

REFERRAL AUTHORIZATION: Your insurance carrier may require a referral from your primary care physician for our services. Please be aware that it is your responsibility to obtain all necessary referrals prior to therapy. If your insurance carrier requires an authorization for service, no service will be rendered until the authorization is obtained.

CANCELLATION AND/OR NO-SHOW POLICY: Scott J Banks, DC, PC urges you to keep every appointment, as consistent treatment provides optimal benefit. In the event you need to cancel an appointment, we require at least 24 hours notice, excluding Sunday. Patients who cancel without proper notice or fail to show for a scheduled appointment will be subject to a $50.00 charge for each occurrence. Arrival more than 15 minutes after the time of your scheduled appointment may be considered a failed appointment.

ASSIGNMENT OF BENEFITS: I authorize payment of my Medicare and/or Insurance benefits to be made directly to Scott J Banks, DC, PC on my behalf for services rendered. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me, I will endorse such payments to Scott J Banks, DC, PC within five (5) days of receipt of such payment.

FINANCIAL/INSURANCE RESPONSIBILITY FOR ALL SCOTT J BANKS, DC, PC SERVICES: I understand and agree to the following policies regarding financial and insurance responsibilities. Payment is required at or before each visit. I am responsible for charges incurred for all treatment rendered. This responsibility includes co-pay, co-insurance, deductible amounts, non-covered and excluded items not paid for by my insurance carrier or other party responsible for coverage of my medical expenses. I agree that I am responsible for any payments for services my insurance carrier determines, either now or at a later date, to be unreasonable or not medically necessary. I further understand, Scott J Banks, DC, PC will not be obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance claim. I also agree to be responsible for costs and expenses, including court costs, attorney fees and interest, should it be necessary for Scott J Banks, DC, PC to take action to secure payment of an outstanding balance owed.

NO GUARANTEES: I recognize that the practice of chiropractic is as much an art as a science, and therefore acknowledge that no guaranties have been or can be made regarding the likelihood of success or outcome of any treatment and/or therapy rendered at New Life Chiropractic, PC

REVOCATION OF AUTHORIZATIONS: These authorizations may be revoked by me, in writing, at any time. Such revocation will not affect my financial responsibility to pay for services rendered.

PATIENT ACKNOWLEDGMENT: I certify that the information I provide to my doctors, therapists and insurance company is correct. I certify that I am here to receive medical care and for no other purpose. I do not represent any third party.

By signing and dating this form I acknowledge I have discussed, or have had the opportunity to discuss, with my doctor the nature and purpose of Chiropractic treatment in general and my treatment in particular (including my Individualized Plan of Care) as well as the contents of these Acknowledgements and Authorizations.

I consent to the chiropractic treatments offered or recommended to me by my Doctor. I intend this consent to apply to all my present and future Chiropractic care.

Patient's Signature	Date
Witness	Date