



**PATIENT CONSENT  
FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION  
TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS**

\_\_\_\_\_ hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Notice of Privacy Practices has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone, or by e-mail.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for *all future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

**I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.**

\_\_\_\_\_  
Name of Patient/Individual (Please print)

\_\_\_\_\_  
Signature of Patient/Individual

\_\_\_\_\_  
Signature of Legal Representative  
(e.g., Attorney-In-Fact, Guardian, Parent if a minor)

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Witness



***Family Care Chiropractic***

**Jared C. Rosenberg, DC**

251 Medical Center Blvd, Suite 300A

Webster, TX 77598-4213

Phone: (281) 554-5308 \* Fax: (281) 605-5539

rosenbergdc@gmail.com

**PLEASE READ THE FOLLOWING QUESTIONS  
AND CIRCLE YES or NO**

1. Do you have any objections to us faxing or mailing your chart notes, health history, progress notes to an insurance company asking for your records when reviewing coverage on your claims? YES / NO
2. Your chart is filed, but not locked away. Do you have any objections to the storage of your chart in this manner? YES / NO
3. If a doctor, attorney, insurance company, workers compensation adjustor, motor vehicle accident adjustor ask for your records, do you have any objections to your health information and notes faxed or mailed to them? YES / NO
4. If a doctor, attorney, and/or insurance adjustor calls about your case for information pertaining to your progress or status, do you have any objections to the doctor at Family Care Chiropractic answering these questions over the phone? YES / NO
5. If the staff makes telephone calls to verify health insurance coverage, ask about status on a claim filed, or any other communication with your insurance company in order to aid in filing your insurance, do you have any objections or restrictions? YES / NO
6. Do you have any restrictions or concerns about privacy or details of your health records? YES / NO

Please explain any YES answer above:

\_\_\_\_\_  
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Relationship to Patient

\_\_\_\_\_  
Date Signed



**CONSENT TO TREAT and PAYMENT RESPONSIBILITY**

I, \_\_\_\_\_ hereby give consent to the doctors and staff of Family Care Chiropractic to provide chiropractic care to myself and/or my family. I understand there is a fee for services and understand that the fee is payable at the time services are rendered. I hereby agree to such fees and understand that I am liable for any and all legal fees if collection services are necessary. I FURTHER UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. FURTHERMORE, I UNDERSTAND THAT **FAMILY CARE CHIROPRACTIC** WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTION FROM THE INSURANCE COMPANY AND THAT ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO **FAMILY CARE CHIROPRACTIC** WILL BE CREDITED TO MY ACCOUNT ON RECEIPT. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT **I AM PERSONALLY RESPONSIBLE FOR PAYMENT.** I ALSO UNDERSTAND THAT IF I SUSPEND OR TERMINATE TREATMENT, ANY FEES FOR PROFESSIONAL SERVICES RENDERED TO ME WILL BE IMMEDIATELY DUE AND PAYABLE BY ME.

**RELEASE AND ASSIGNMENT**

I authorize the release of any medical or other information necessary to process claims. I also request payment of Medical, Chiropractic, PIP, or 3<sup>rd</sup> Party benefits be paid directly to Jared C. Rosenberg, DC, or Family Care Chiropractic for services rendered. This assignment is irrevocable until all debts on this account have been paid in full.

\_\_\_\_\_  
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\_\_\_\_\_  
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\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date Signed

In Case of an emergency: Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_



**TO THE PATIENT: PLEASE READ AND SIGN BOTH PARTS OF THIS FORM. ONE SIGNATURE ENABLES OUR OFFICE TO RECEIVE RECORDS FROM HOSPITALS, DR'S OFFICES, ETC. THE OTHER ALLOWS OUR OFFICE TO SEND YOUR RECORDS TO ANY HOSPITAL, DR'S OFFICES, ETC, UPON REQUEST.**

**TO ALL PHYSICIANS AND OTHER HEALTH PROFESSIONS:**

YOU ARE AUTHORIZED TO PROVIDE ALL HOSPITALS HEALTH CARE INSTITUTIONS, PHYSICIANS, AND HEALTH CARE PROFESSIONALS WITH INFORMATION CONCERNING EXAMINATION, DIAGNOSIS, TREATMENT, HEALTH CARE, ADVICE OR SUPPLIES PROVIDED TO THE PATIENT. THIS INFORMATION WILL BE USED FOR COMMUNICATION BETWEEN ATTENDING PHYSICIANS/HEALTH CARE PROVIDERS.

THIS AUTHORIZATION IS VALID FOR AS LONG AS I AM A PATIENT AT FAMILY CARE CHIROPRACTIC CLINIC. I KNOW THAT I HAVE A RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION UPON REQUEST AND AGREE THAT A PHOTOCOPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL.

\_\_\_\_\_  
Name of Patient/Individual (Please print)

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Signature of Patient/Individual

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Signature of Legal Representative  
(e.g., Attorney-In-Fact, Guardian, Parent if a minor)

\_\_\_\_\_  
Relationship to Patient

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Date Signed

**TO ALL PHYSICIANS AND OTHER HEALTH PROFESSIONS:**

YOU ARE AUTHORIZED TO PROVIDE FAMILY CARE CHIROPRACTIC CLINIC WITH INFORMATION CONCERNING EXAMINATION, DIAGNOSIS, TREATMENT, HEALTH CARE, ADVICE OR SUPPLIES PROVIDED TO THE PATIENT. THIS INFORMATION WILL BE USED FOR COMMUNICATION BETWEEN ATTENDING PHYSICIANS/HEALTH CARE PROVIDERS.

THIS AUTHORIZATION IS VALID FOR AS LONG AS I AM A PATIENT AT FAMILY CARE CHIROPRACTIC CLINIC. I KNOW THAT I HAVE A RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION UPON REQUEST AND AGREE THAT A PHOTOCOPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL.

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Signature of Patient/Individual

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Relationship to Patient

\_\_\_\_\_  
Date Signed



**Informed Consent to Rehabilitation, Work Hardening, Work Conditioning, Pain Management, Chiropractic Care, Diagnostic Testing, Examination Procedures, and Nutritional Counseling and Therapy**

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

The primary treatment used by a doctor or therapist at this facility is the art and philosophy of rehabilitation and diagnostics by any qualified means which may be necessary. Pictures of you and your condition may be taken and video reproduction of examinations and treatment may be done for any number of reasons. We at times do like to keep a photographic journal of your case and findings. If you ever have a problem with this, please let us know. Signature of this document gives us consent to do the aforementioned, unless your refusal for photographic and/or video reproduction is attached in writing.

**The Nature of applied treatments at our facility**

The doctors and or therapists at this facility will use any means such as stretching, weight training, work simulation therapy, cardiovascular training, soft tissue therapy or manipulation by trained personnel to help you the patient. There may be a number of receptor-based therapies provided to better serve you. There may also be the usage of certain electrical modalities or adjunct therapy to help your condition. At any time if you have questions about your therapy, please talk to the therapist or doctor. There may be procedures done such as Water therapy, Interferential therapy, Ultrasound, Micro current Therapy, High Volt and low Volt Therapy, Low Level Laser Therapy, or traction of a particular joint or body part. There may also be situations in which taping or stabilization or bracing of a joint is necessary in order to get the body's desired healing effect. Vitamins, herbs and homeopathic remedies may be recommended. There may at times be recommendations to other specialist for your condition.

**The Materials Risk Inherent to the above Therapy**

As with any health care procedure there are certain complications which may arise during any of the treatment listed above. Those complications include but are not limited to fractures, disc injuries, dislocations, muscle strains, soft tissue injuries, Horner's Syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. There is also a risk of stroke with various manipulative procedures, especially to the neck or cervical spine. If you feel light-headed, dizzy, disoriented, and/or confused after manipulative therapy, please notify the doctor immediately. There could also be complications from burns, spread of infections, spread of malignancies, allergic reactions, skin reactions or other complications from the usage of the adjunct therapy that was listed above as well as diagnostic procedures. Upon signature of this document you give the therapists or practitioner at this facility the right to perform the necessary procedures for treatment and diagnosis which includes a complete physical and neurological examination, as well as electrical diagnostic testing as necessary. During the examination you may be gowned so that the injured area can properly be assessed and treated. Upon signature of this document you are giving consent to be gowned and examined.

**Necessary Referrals for Testing or Outside Consults**

As a result of your history, physical examination or other factors you may need to be referred out for other testing procedures and or referrals may need to be made to other practitioners. Upon signature of this document you the patient understand that this is a possibility and agree to follow any and all recommendations made by the referring practitioner. If the decision is made not to participate in any referrals made it is agreed that the referring doctor will be notified of that decision. You as the patient should know that you always have the right to choose your own doctor or specialist or diagnostic company or facility if such referrals are made. We may make suggestions but you the patient have the right of choice. You may have been referred for services that we decide not to offer due to a lack of observed medical necessity during consultation.

\_\_\_\_\_  
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Relationship to Patient

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Date Signed