Keith Shotwell, D.C.

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Patient Consent

Consent for Treatment:

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

Release of Information:

By signing this form, you are granting consent to Body in Motion Chiropractic to use and disclose your protected health information for the purpose of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sing this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by calling our office at _____. You have the right to request us to retract how we use and disclose your protected health information for the purpose of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Medicare and Medicaid Consent To Release Information:

I certify that the information given by me in allying for payment under Title XVII and/or Title XI of Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim.

Verification of Non-Pregnancy (Female Patients Only):

By my signature in this form, I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of my last menstrual period. _____.

Date: _____

_____
Print Patient's Name

_____
Patient's Signature

_____
Other Than Patient, Print Name & Relationship

_____
Witness