**HIPAA**

**AUTHORIZATION AND ASSIGNMENT OF BENEFITS**

To: Dr. John Cowan/Cowan Chiropractic Clinic, PC

In consideration of your undertaking to treat me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my health to any insurance company, attorney, or adjuster in order to process my claim for reimbursement of charges incurred by me at Cowan Chiropractic Clinic. In addition, I hereby authorize you to release any of my health information with other doctors as needed to ensure better patient care.
2. I give assignment and lien against any claims against a third party whose negligence may have caused the patient's injury, up to the amount of the bill for treatment. I further authorize that any insurance company paying for treatment received at Cowan Chiropractic Clinic, should send all payments directly to Cowan Chiropractic Clinic and in the name of Dr. John Cowan only.
3. In the event any insurance company obligated to make payment to me or to you for charges made for your services, and has refused to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company. I also authorize you to prosecute said action either in my name or your name as you see fit and further authorize you to compromise, settle or to otherwise resolve said claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company (or companies) obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you.
4. I waive the Statue of Limitations regarding my doctor's right to recover.
5. I have read and understand the HIPPA Notice Privacy Practices located in the reception area of Cowan Chiropractic Clinic.

**AUTHORIZATION TO PAY DIRECTLY TO DOCTOR**

TO: _____/_____

Patient Name Name of Insurance Company(s)/attorney

In consideration of the services rendered and to be rendered, I authorize and assign the direct payment to Dr. John Cowan/Cowan Chiropractic Clinic any sum I now (or hereafter) owe him by my attorney out of the proceeds of any settlement of my case and/or by any insurance company obligated for the charges of his services or otherwise obligated to make payment to me or him whether based in whole or in part upon the charges made for services rendered by him.

Signature_____ Date_____

# Cowan Chiropractic Clinic, P.C.

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## Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____ _____ _____

Print Name Signature Date

**Consent to evaluate and adjust a minor child:**

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

**Pregnancy Release:**

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

_____ _____

Signature Date