Patient Authorization

The signature of the patient below gives authorization to the office of New Health Chiropractic, to comply with all of the following options. If you reject any of these options, please do so by placing your initials to the right of the option, along with today's date:

1. Mail out reminder cards for upcoming office visits.
2. Permission to contact my place of employment regarding my appointments.
3. Permission to leave messages at my place of employment regarding my appointment.
4. Permission to leave detailed messages on answering machine regarding appointment, treatment, or account balance.
5. Consent to file insurance claims.
6. Authorization to submit additional medical information to insurance companies to expedite handling of my claim.
7. Authorization to contact my medical physician regarding my medical history.
8. Authorization to E-Mail and/or 'text' appointment reminders and/or office announcements or updates.
9. Please name individuals/family members to whom you give consent to access medical records/account balances. _____

Print name of Patient: _____

Parent/Guardian Signature: _____

Date: _____

Please Turn Over

CONSENT TO TREATMENT OF MINOR PATIENT

I hereby authorize Dr. Justin Pals, D.C. or Dr. Kody Adams, D.C. to perform diagnostic tests and render chiropractic treatment to my minor child _____

date of birth _____**.**

I hereby affirm that I have the legal right to select and authorize health care services for the minor child named above.

(If applicable) Under the terms and conditions of my dissolution of marriage or separation, I have the legal right to select and authorize this care for my minor child without consent of my spouse/former spouse. If my authority to authorize such care is revoked or modified, I will immediately notify this office.

I understand that the practice of chiropractic medicine is not an exact science and that my child's care may involve the making of judgments based on the facts known to the doctor at the time; that it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications; that an undesirable result does not necessarily indicate an error in judgment or treatment; that no guarantee as to results has been made to or relied upon by me, and I wish to rely on the doctor to exercise judgment during the course of the procedure which he or she feels at the time, based on the facts then known, is in my child's best interests.

I have also been advised that, although the incidence of complications associated with chiropractic services is very low, anyone undergoing adjustment or manipulative procedures should know of possible complications which have been alleged. These include, but are not limited to, fractures, disk injuries, strokes, dislocations, sprains and those which related to physical aberrations unknown or reasonably undetectable by the doctor.

I have read or have had read to me the above consent. I have also had an opportunity to ask questions about its contents, and by signing below on behalf of my minor child, acknowledge my understanding of its contents.

_____ _____

Date Minor Child's Name Printed

_____ _____

Authorized Parent/Guardian Printed Name Authorized Parent/Guardian Signature

_____

Relationship of Authority to Minor Patient: