

R. Kershaw, D.C

Neck & Back Center of Pasadena

J. Strey, D.C.

2700 East Foothill Blvd, Suite 202, Pasadena, CA 91107

DATE _____

CONSENT FOR TREATMENT AND AUTHORIZATION TO PERFORM SERVICES

- I have been informed by this office that chiropractic examinations, diagnostic x-rays, adjustments and other chiropractic procedures including various modes of physical therapy may be advisable in my case so that a complete analysis can be made of my present musculoskeletal problem (or illness). I authorize the Neck and Back Center of Pasadena/ Chiropractic Physician or anyone working in this office authorized by the Chiropractic Physician to perform such examinations and treatments necessary to treat my present problem or illness.
- To the best of my knowledge I am NOT PREGNANT at this time.
- I have had an opportunity to discuss with the Neck & Back Center of Pasadena and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine and all healthcares, the practice of chiropractic carries some risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known. I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

AUTHORIZATION TO RELEASE INFORMATION AND NOTICE OF ASSIGNMENT

- I authorize the doctor and staff to release any information deemed appropriate concerning my physical condition to any insurance company; attorney or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered and hereby release Neck & Back Center of Pasadena of any consequences thereof.
- I authorize direct payment of any medical expense benefits allowable to Neck & Back Center of Pasadena as a payment toward the total charges for professional services rendered. I agree a photo copy of this agreement can serve as the original.

SIGNED _____

PRINT NAME _____

WITNESS _____