Consent Form

General Consent: The undersigned hereby consents to evaluation and treatment rendered according to the applicable standards of care. It is understood that options exist for treatment and all treatments are choices between risks and benefits. If the risks and benefits of proposed treatments are not clear to me, I understand that further information may be requested from Dr. Bourne. The information within this chart is confidential. I understand that all requests for release of records must be in writing. Protected health information will be released with written authorization, with minimum disclosure necessary as related to my care. I was given a copy of the private policy notice during my initial visit which I have read and fully understand. I also understand that I have a responsibility to communicate honestly with Dr. Bourne and to notify her of any changes in my health status.

Patient initials: _____

Financial Awareness and Consent: I understand that I am financially responsible for all charges incurred by me. If HCFA forms are sent to my insurance company for me and payments are sent to me instead of to ICC, I am responsible for full payment to ICC. If there is no insurance carrier being used, I will make the payment at time of service. **I understand that Dr. Bourne's time is as valuable as my own. If I am unable to keep the appointment, I will give 24 hours notice otherwise, I will be charged for the time reserved.**

Patient Initials: _____

Patient Consent for Contact: I give consent to Dr. Sherin Bourne, and the other health care professionals working at Integrative Chiropractic Center to my contact information. This includes my name, address, phone number, and email address in order to contact me regarding appointment reminders, newsletters, announcements, information about alternatives to my present care, or other health related information that may be of interest to me. Messages for appointment reminders may be left on my answering machine if I am not home.

Patient Initials: _____

Print Name: _____

Patient Signature_____ Date: _____