Dr. Russell's Office Policy

Patient Name: ____

Initials _____ **AUTHORIZATION FOR PAYMENTS:**

It is the policy of this office to extend to our patients the courtesy of the allowing you to assign your insurance benefits directly to us.

1. The privilege of insurance assignment begins when our office receives your insurance forms and coverage has been verified.
2. If filing insurance, I hereby authorize Dr. Russell to furnish any and all medical records that my insurance company may request for payment in accordance with this policy.
3. If I am choosing not to file insurance, I understand that I am expected to make payment at the time of service and agree to make payment in accordance with this policy.

Initials _____ **INFORMED CONSENT:**

The patient has been informed and understands that the practice of the Chiropractic includes treatment by adjustment or manipulation of the patient's body part, particularly the spine. Adjustment of the body and the spine necessarily involves applying pressure, by the use of "Hands On" techniques requiring Dr. Russell to use his hands and body to cause appropriate movement within the patient's body. Manipulation is gentle and should not cause damage to the patient.

If at any time during the examination or treatment you feel uncomfortable due to body contact which occurs, please immediately inform Dr. Russell and give sufficient notice to allow him to alter the treatment plan as appropriate.

Initials _____ **FINANCIAL ARRANGEMENTS:**

We have an open front desk and many of our financial arrangements are discussed at the front counter. Please do not initial this if you would prefer to have your financial arrangements discussed in a more private place.

I have read and fully understand all of the above information. I also understand that my refusing to sign this form means that I will not be treated at this office.

Initials _____ **PICTURE PERMISSION**

By initialing this you give Russell Chiropractic permission to use your picture on our office board, TV, and any other forms of social media used by our office.

*I give my permission for the following person(s) to access my medical records:
____

Patients/Guardian's Signature: ______________________ Date: ____________