Complete Health of Lawrenceville

Berkowitz and Clancey PC
136 Franklin Corner Road
Lawrenceville, NJ 08648
(609)-912-0440

Informed Consent for Chiropractic Treatment & Limited Authorization and Release

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of therapy modalities and diagnostic x-rays, on myself (or on the patient named below for whom I am legally responsible) by the licensed doctors of chiropractic of Complete Health of Lawrenceville, or any doctor, who now or in the future, works as a relief doctor.

I have had the opportunity to discuss with my doctor the nature and purpose of chiropractic adjustments and other procedures and understand that spinal manipulation involves the doctor placing his or her hands on my spine and delivering a quick thrust or impulse to the involved area(s). I also understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to: fractures, disc injuries, strokes, dislocations, sprains, soreness, and physical therapy burns. I understand and comprehend all such risks and complication. I, by my signature below, confirm and accept care and therefore consent to and agree to those treatments deemed necessary by my doctor to be in my best interest.

I authorize payment of insurance benefits direction to Complete Health of Lawrenceville. I understand and agree to allow this office to use my Confidential Patient Health Information forms for the purpose of treatment, payment, healthcare operations and coordination of care and authorize Complete Health of Lawrenceville to communicate with my medical physician(s) about my condition and treatment. I understand and agree that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand the Federal Government has deemed it mandatory to notify my doctor of any other party or insurance company who may be responsible for reimbursement for my treatment. I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

I have also read, or have had read to me the above informed consent, authorization and release. I have had an opportunity to ask any and all questions about its consent, and by signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for future condition(s) for which I seek treatment in this office.

To be completed by the patient's representative, if necessary
(eg: if the patient is a minor, if the patient does not speak English, or if the person is physically or mentally incapacitated)

_____ _____

Print Patient Name ***Print Name of Legal Representative***

_____ _____

Signature of Patient ***Signature of Legal Representative***

_____

Date