

KONOPKA CHIROPRACTIC PLLC

200 Buttercup Creek Blvd. Suite 106
Cedar Park, Texas 78613

New Patient Intake Form

Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible: _____) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician. I further understand that such chiropractic services may be performed by the Physician **Konopka Chiropractic, PLLC** and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with **Dr. Thomas Konopka** 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 to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all 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 an 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. To be completed by the patient: To be completed by the patient’s representative, if necessary, (e.g. if the patient is a minor or is physically or mentally incapacitated)

Print Patient’s Name or Name of Representative Date

Signature of Patient Signature or of Representative

Date

Consent for Use and Disclosure of Information

By signing below, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent. I request that payment of authorized Medicare/insurance carrier benefits be made on my behalf to Konopka Chiropractic PLLC for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare/Medicaid Services and it’s agent and/or any other Insurance Carriers for which I have coverage, any information needed to determine these benefits or the benefits payable for related services. I agree to provide all referral and treatment plan(s) as required by my insurance carrier(s). All co-pays must be paid at the time of service in accordance with the contracted Insurance Carrier agreements.

Patient/Guarantor Signature Date: _____
Print Full Name: _____

FOR MORE INFORMATION OR TO REPORT A PROBLEM: If you have questions or would like additional information, please contact the HIPPA Policy Officer for this practice. If you believe your privacy rights have been violated, you may file a written complaint with the Secretary of Health and Human Services. RAAA-AC2:1m-07/03