



# BACK IN MOTION, P.S. C H I R O P R A C T I C

WELCOME and THANK YOU for trusting us with your child/children applying as patient(s) in our clinic. We are a very unique team specializing in researched, evidence-based, spinal pediatric adjusting and postural rehabilitation that has helped infants, young children, and even teenagers with early onset to advanced spinal distortion and injuries known to cause developmental and lifelong health problems. Because of this specialized approach, we may not accept your child as a patient until we are absolutely certain we know the cause of their condition; perform the necessary tests to determine the optimal program of correction, and we are completely confident you and your child place their health as a TOP PRIORITY. At that time we will make specific recommendations. Thank you again for giving your child the opportunity to apply as a patient. **Please note: paperwork must be completed in pen and filled out in its entirety. Please read through the instructions thoroughly and fill out as directed for any and all areas that apply.**

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*PATIENT NAME*

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*DATE COMPLETED*

## Patient Information

Name: \_\_\_\_\_ (Age) \_\_\_\_\_ Gender: M F  
Home Address: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

Name of Mother/Guardian: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_  
Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ (Age) \_\_\_\_\_ Marital Status: S M D W Work Phone: ( ) \_\_\_\_\_  
Home Address (if different): \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Email: \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Name of Father/Guardian: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_  
Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ (Age) \_\_\_\_\_ Marital Status: S M D W Work Phone: ( ) \_\_\_\_\_  
Home Address (if different): \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Email: \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Primary Care Physician Name: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Primary Care Physician address: \_\_\_\_\_ PCP Phone: \_\_\_\_\_  
Primary Care Physician group (i.e. Rockwood, Providence, Kaiser, etc.): \_\_\_\_\_

How were you referred to this office? \_\_\_\_\_

## Purpose For This Visit

Reason for this visit: \_\_\_\_\_

Is this related to an accident or specific injury (other than auto or work-related)\*?  Yes  No If yes, when: \_\_\_\_/\_\_\_\_/\_\_\_\_  
**\*If your child's symptoms are the result of an auto accident or work-related injury, please ask the front-desk person for the corresponding application.**

Describe incident or reason for onset of symptoms: \_\_\_\_\_

**Please use the *General Symptoms Chart* on the next page to provide a detailed notation of your child's symptoms.**

When did these symptoms begin? \_\_\_\_/\_\_\_\_/\_\_\_\_ Are they:  Constant  Intermittent  Activity-related  
Are they getting worse?  Yes  No Do they interfere with:  School  Sleep  Hobbies/Play  Daily Routine  
Explain: \_\_\_\_\_

What activities aggravate these symptoms? \_\_\_\_\_

Is there anything that relieves your symptoms?  Yes  No If yes, explain: \_\_\_\_\_

Has your child experienced these symptoms before (if not accident/injury related)?  Yes  No  
If yes, explain: \_\_\_\_\_

Has your child been treated for this?  Yes  No When was the last treatment? \_\_\_\_/\_\_\_\_/\_\_\_\_  
Name of treating practitioner/facility? \_\_\_\_\_  
What treatment(s) was performed? \_\_\_\_\_

How did your child respond? \_\_\_\_\_

## GENERAL SYMPTOMS CHART

Please use the following notations on the figures below to indicate the type and location of your child's symptoms, as it relates to the purpose of your visit today.

**Please rate each region on the VAS pain scale 1-10, 10 being the most severe.**

A = ACHE

B = BURNING

P = PINS & NEEDLES

G = STABBING

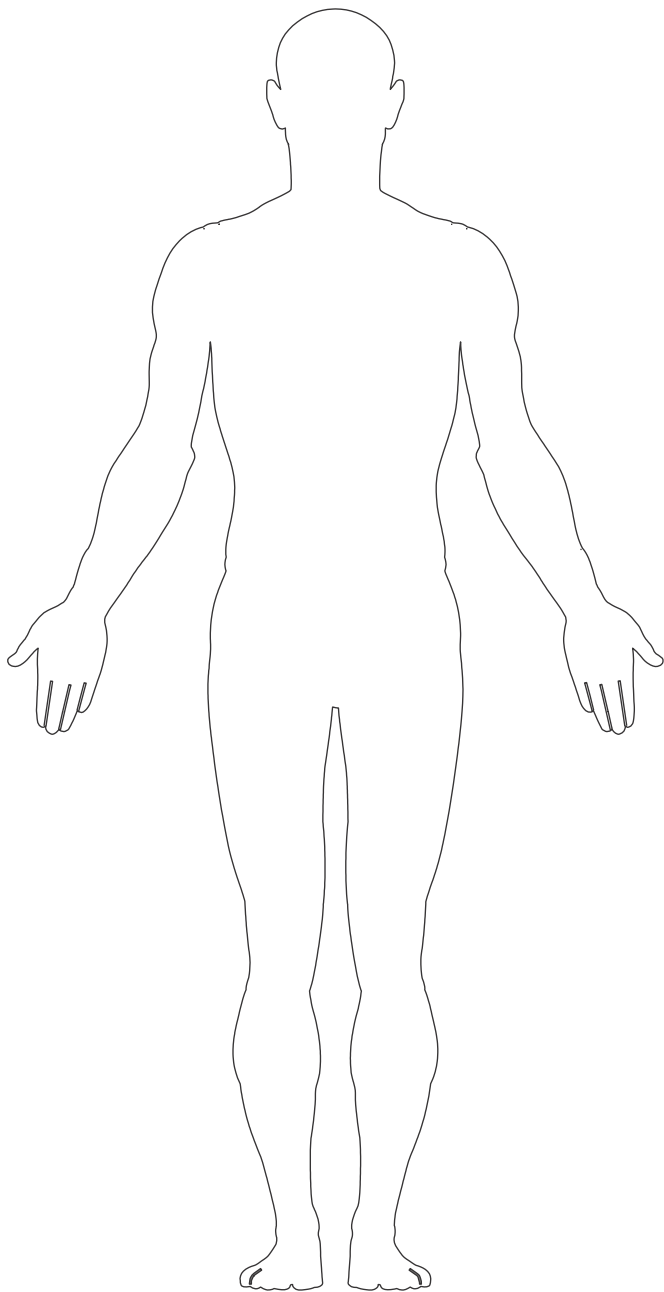
M = SPASMS

F = STIFFNESS

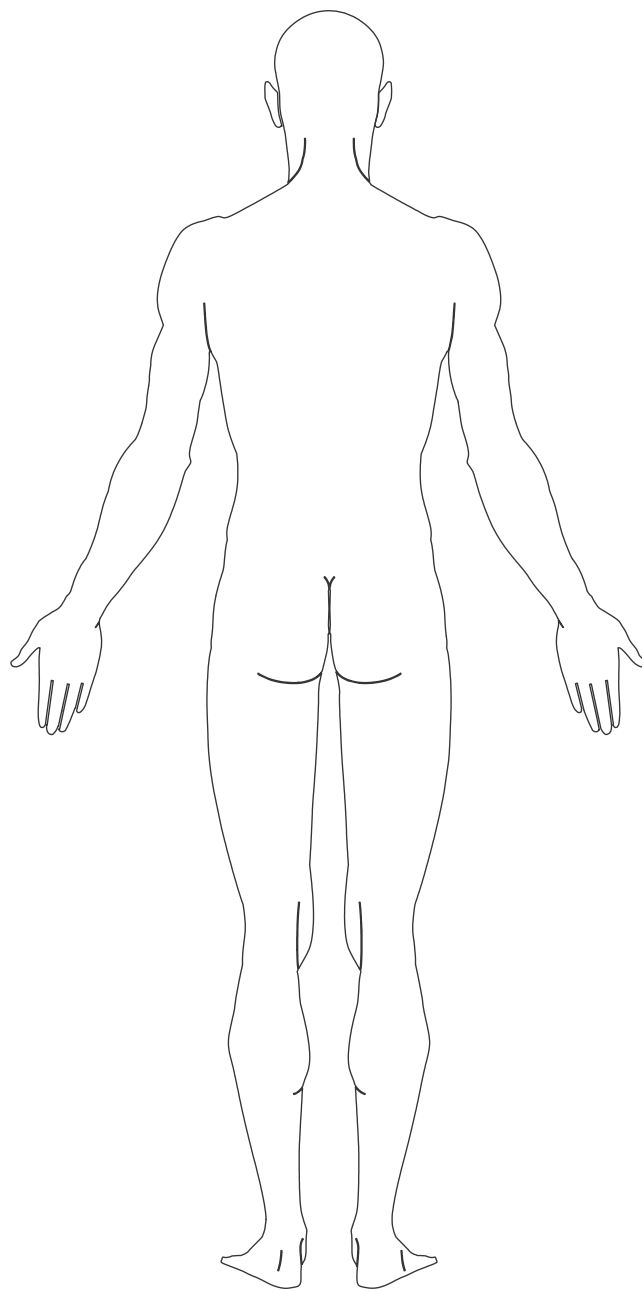
N = NUMBNESS

T = TINGLING

O = OTHER



FRONT



BACK

If you marked "O" for Other on any part, please explain below:

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## Health Conditions

Your spine is the foundation of health and core strength in your body. Shifts in the vertebrae or sections of the spine will spread ultimately causing weakness and distortion to ALL the areas of the spine. These distortions are reflected in abnormal posture. Research shows abnormal posture leads to chronic pain, disease and possibly a shortened life span.<sup>1</sup> Please answer the following questions accurately so we may determine the full extent of your child's condition.

### HISTORY OF TRAUMA

The below-listed traumas may lead to misalignment of the individual vertebrae, soft tissue injury to the supportive structures of the spine, as well as shifts and distortions in whole curves and sections of the spine. Please check any of the following if your child has experienced such (*if you check an item with an asterisk, please offer a detailed explanation*):

- Fell from a height of two (2) feet or more as an infant
- Experienced a fall that left a bruise or lump on their head or other resulting trauma\*
- Rough shaking as an infant
- Were involved in a car accident (*if you check this item, please ask the front desk person for the corresponding form*)
- Experience broken bones or debilitating injuries\*
- Difficult Birth (see below)

Explanation of (\*) item(s): \_\_\_\_\_

### BIRTH EXPERIENCE:

How long was labor? \_\_\_\_\_

Describe any complications: \_\_\_\_\_

Type of delivery:  Vaginal  C-Section  Vacuum Extraction  Forceps Assistance

### VACCINATION HISTORY

What vaccinations has your child received (please note at what age and where each was received):

1. \_\_\_\_\_ Age:  Mos.  Yrs. Where received: \_\_\_\_\_
2. \_\_\_\_\_ Age:  Mos.  Yrs. Where received: \_\_\_\_\_
3. \_\_\_\_\_ Age:  Mos.  Yrs. Where received: \_\_\_\_\_
4. \_\_\_\_\_ Age:  Mos.  Yrs. Where received: \_\_\_\_\_
5. \_\_\_\_\_ Age:  Mos.  Yrs. Where received: \_\_\_\_\_

### 6. COVID 19:

- Has your child been vaccinated for COVID-19?*  Yes  No
- Has your child received 1 or more boosters for COVID-19?*  Yes  No
- Has your child ever had an active COVID-19 infection?*  Yes  No  Unsure

**Please check any of the following responses your child experienced as a result of a vaccination (please indicate which vaccination caused the condition by writing the corresponding number next to that condition).**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Swelling, redness, heat/hardness of site   | <input type="checkbox"/> Body rash or hives                     | <input type="checkbox"/> High fever (over 103 degrees) |
| <input type="checkbox"/> High-pitched screaming                     | <input type="checkbox"/> Extreme sleepiness or unresponsiveness | <input type="checkbox"/> Body twitching or paralysis   |
| <input type="checkbox"/> Breathing problems (asthma, etc.)          | <input type="checkbox"/> Excessive bleeding or anemia           | <input type="checkbox"/> Head banging                  |
| <input type="checkbox"/> Excessive diarrhea or chronic constipation | <input type="checkbox"/> Loss of memory/foggy state             | <input type="checkbox"/> Muscle weakness               |
| <input type="checkbox"/> Chronic ear or respiratory Infections      | <input type="checkbox"/> Vision or hearing disturbances         | <input type="checkbox"/> Joint pain                    |
| <input type="checkbox"/> Crossing of eyes                           | <input type="checkbox"/> Seizures                               | <input type="checkbox"/> Other (please explain)        |

Explanation(s): \_\_\_\_\_

1. Postural and Degenerative Kyphosis: Freeman JT. Posture in the Aging and Aged body. JAMA 1957, Oct 19: 843-846.

## Health Conditions *continued...*

### CERVICAL SPINE (NECK)

Misalignment of the individual vertebrae or distortion of the complete cervical curve (neck) originating in the neck or a compensation from postural distortions in other areas of the spine may result in many health conditions. Has your child experienced any of these symptoms presently or in the past?

**Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Neck Pain                       | <input type="checkbox"/> Headaches              | <input type="checkbox"/> Sinusitis             |
| <input type="checkbox"/> Pain in shoulders/arms/hands    | <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Allergies/Hay fever   |
| <input type="checkbox"/> Numbness/tingling in arms/hands | <input type="checkbox"/> Visual disturbances    | <input type="checkbox"/> Recurrent colds/Flu   |
| <input type="checkbox"/> Hearing disturbances            | <input type="checkbox"/> Coldness in hands      | <input type="checkbox"/> Low Energy/Fatigue    |
| <input type="checkbox"/> Weakness in grip                | <input type="checkbox"/> Thyroid conditions     | <input type="checkbox"/> TMJ/Pain/Clicking     |
| <input type="checkbox"/> Colic                           | <input type="checkbox"/> Ear Infections         | <input type="checkbox"/> Flu/Stomach disorders |
| <input type="checkbox"/> Sore throats                    | <input type="checkbox"/> Learning disabilities  | <input type="checkbox"/> Hyperactivity/ADD     |
| <input type="checkbox"/> Auto-Immune Diseases            | <input type="checkbox"/> Other (please explain) |  |

Explanation(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### THORACIC SPINE (UPPER BACK)

Misalignment of the individual vertebrae or distortion of the upper thoracic curve (upper back) originating in the upper back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Has your child experienced any of these symptoms presently or in the past?

**Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Heart Palpitations                             | <input type="checkbox"/> Heart Murmurs                       | <input type="checkbox"/> Asthma/Wheezing               |
| <input type="checkbox"/> Shingles                                       | <input type="checkbox"/> Shortness of Breath                 | <input type="checkbox"/> Tachycardia (fast heart beat) |
| <input type="checkbox"/> Upper Back Pain                                | <input type="checkbox"/> Pain On Deep Inspiration/Expiration | <input type="checkbox"/> Other (please explain)        |
| <input type="checkbox"/> Recurrent Lung Infections/Bronchitis/Pneumonia |  |  |

Explanation(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### THORACIC SPINE (MID BACK)

Misalignment of the individual vertebrae or distortion of the mid thoracic curve (mid back) originating in mid back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Has your child experienced any of these symptoms presently or in the past?

**Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Mid Back Pain   | <input type="checkbox"/> Nausea           | <input type="checkbox"/> Diabetes               |
| <input type="checkbox"/> Pain in Ribs/Chest  | <input type="checkbox"/> Ulcers/Gastritis | <input type="checkbox"/> Hypoglycemia           |
| <input type="checkbox"/> Indigestion/Heartburn   | <input type="checkbox"/> Reflux           | <input type="checkbox"/> Diabetes               |
| <input type="checkbox"/> Liver problems  | <input type="checkbox"/> Spleen problems  | <input type="checkbox"/> Other (please explain) |
| <input type="checkbox"/> Tired/Irritable after eating or when not having eaten for a while |   |   |

Explanation(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Health Conditions *continued...*

### LUMBAR SPINE (LOW BACK)

Misalignment of the individual vertebrae or distortion of the lumbar curve (low back) originating in the low back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Has your child experienced any of these symptoms presently or in the past?

**Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Pain in hips/legs/feet                      | <input type="checkbox"/> Weakness/injuries in hips/knees/ankles | <input type="checkbox"/> Low back pain         |
| <input type="checkbox"/> Numbness/tingling in your legs/feet         | <input type="checkbox"/> Recurrent bladder infections           | <input type="checkbox"/> Coldness in legs/feet |
| <input type="checkbox"/> Frequent/difficulty urinating               | <input type="checkbox"/> Muscle cramps in legs/feet             | <input type="checkbox"/> Constipation/Diarrhea |
| <input type="checkbox"/> Menstrual irregularities/cramping (females) | <input type="checkbox"/> Other (please explain)                 |  |

Explanation(s): \_\_\_\_\_

### OTHER

Please list any health conditions not mentioned: \_\_\_\_\_

Please list any medications (include name, dose, for what condition, and how long your child has been taking it): \_\_\_\_\_

Please list any surgeries (include type of surgery and date it was performed): \_\_\_\_\_

## Family Health History

Have any of your family members ever been diagnosed with the following? ***If so, please indicate "P" for your child (patient), and "O" for Other than your child, or both if applicable (Items marked with an asterisk, please offer a detailed list or explanation):***

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> ADD                    | <input type="checkbox"/> Allergies/Hay fever* | <input type="checkbox"/> Anemia             | <input type="checkbox"/> Appendectomy         |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Asthma               | <input type="checkbox"/> Bed wetting        | <input type="checkbox"/> Blood sugar problems |
| <input type="checkbox"/> Broken bones/fractures | <input type="checkbox"/> Cancer               | <input type="checkbox"/> Cerebral Palsy     | <input type="checkbox"/> Chicken pox/shingles |
| <input type="checkbox"/> Circulatory problems   | <input type="checkbox"/> Crohn's/Colitis      | <input type="checkbox"/> Depression         | <input type="checkbox"/> Diabetes             |
| <input type="checkbox"/> Ear Infections         | <input type="checkbox"/> Eczema               | <input type="checkbox"/> Eczema/Psoriasis   | <input type="checkbox"/> Epilepsy/seizures    |
| <input type="checkbox"/> Fetal drug exposure    | <input type="checkbox"/> Food allergies*      | <input type="checkbox"/> Gall bladder       | <input type="checkbox"/> Headaches            |
| <input type="checkbox"/> Heart disease          | <input type="checkbox"/> Heart murmur         | <input type="checkbox"/> Hepatitis          | <input type="checkbox"/> Hernia               |
| <input type="checkbox"/> High blood pressure    | <input type="checkbox"/> HIV                  | <input type="checkbox"/> Infectious disease | <input type="checkbox"/> Influenza            |
| <input type="checkbox"/> Kidney Disease         | <input type="checkbox"/> Liver disease        | <input type="checkbox"/> Lumbago            | <input type="checkbox"/> Lung disease         |
| <input type="checkbox"/> Measles                | <input type="checkbox"/> Metal implants       | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Mumps                |
| <input type="checkbox"/> Neurological problems  | <input type="checkbox"/> Osteoporosis         | <input type="checkbox"/> Paralysis          | <input type="checkbox"/> Pleurisy             |
| <input type="checkbox"/> Pneumonia/Bronchitis   | <input type="checkbox"/> Polio                | <input type="checkbox"/> Rash               | <input type="checkbox"/> Rheumatic fever      |
| <input type="checkbox"/> Scoliosis              | <input type="checkbox"/> Seizure disorder     | <input type="checkbox"/> Sickle cell anemia | <input type="checkbox"/> Small Pox            |
| <input type="checkbox"/> Spinal Bifida          | <input type="checkbox"/> Stroke               | <input type="checkbox"/> Thyroid problems   | <input type="checkbox"/> Tonsillectomy        |
| <input type="checkbox"/> Tuberculosis           | <input type="checkbox"/> Varicose veins       | <input type="checkbox"/> Whooping cough     | <input type="checkbox"/> Other*               |

Explanation of (\*) item(s): \_\_\_\_\_

## Experience with Chiropractic

Has your child seen a Chiropractor before?  Yes  No Who? \_\_\_\_\_

Reason for visit(s): \_\_\_\_\_

Did the previous chiropractor take 'before' and 'after' x-rays?  Yes  No What was the diagnosis? \_\_\_\_\_

Did he or she recommend a specific course of treatment?  Yes  No Did they recommend a Home Health Care program?  Yes  No

If yes, what? \_\_\_\_\_

How long was your child treated? \_\_\_\_\_ Last treatment: \_\_\_\_/\_\_\_\_/\_\_\_\_

How did your child respond? \_\_\_\_\_

Are you aware of any poor posture habits in your child?  Yes  No Is there any history of spinal problems in your family?  Yes  No

If yes, explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Pregnancy Release

This is to certify that to the best of my knowledge that my child is not pregnant, and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: \_\_\_\_/\_\_\_\_/\_\_\_\_

Guardian Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

## Authorization of Care

I authorize and agree to allow the doctor and/or his designated staff to work with my child's spine or the spine of the charge I represent through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal bio-mechanical and neurological function.

I understand that I am responsible for all fees incurred for the services provided and agree to ensure full payment of all charges.

The Doctor and/or his staff will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another healthcare practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.

I also clearly understand that if my child/charge does not follow the doctors and/or staff's specific recommendations at this clinic that he/she will not receive the full benefit from these programs; and that if I terminate this care prematurely all fees incurred will be due and payable at that time.

I understand and am informed that in the practice of Chiropractic there are some risks to treatment, including but not limited to: fractures, disc injuries, strokes, dislocations, strains, and death. I do not expect the doctor to be able to anticipate and explain all risks and complications and wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time is in my best interest.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient's Name Printed \_\_\_\_\_

If patient is not your biological child, but a legal charge requiring guardianship for treatment, please complete the following:

Date Guardianship Awarded \_\_\_\_\_ County, State of Guardianship \_\_\_\_\_

I hereby authorize the doctor to administer care as deemed necessary to my charge as appointed to by the courts.

Guardian Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

## In Case of Emergency

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Work Phone ( ) \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_

Cell Phone ( ) \_\_\_\_\_

## Insurance

We may accept assignment of insurance benefits. By signing this policy, you agree to assign your insurance benefits to this clinic. In cases where benefits are not assignable or in any case where your benefit is processed directly to you regardless of assignment, you agree to submit any payments received along with the explanation of benefits to this clinic within 10 days of receipt unless you have paid for the services represented by said payment in full at the time of service. In no case will an assignment alleviate you of your obligation for payment of services received.

Your insurance plan is a contract between you and your insurance company. This clinic is not a party to that contract and therefore cannot modify the terms of that contract. Payment for treatment you receive from this clinic is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you provide us with the necessary billing information, assign your benefits to this clinic and agree to permit us to release the necessary medical information required to secure payment. In the event we do accept assignment of benefits we require that you provide a credit card with authorization to bill that account any balance or make other payment arrangements. We will make every effort to ensure that your insurance carrier properly processes your services for payment. In some circumstances we may require your assistance. If your insurance company has not paid your account in full within 60 days and you refuse to assist us in dealing with your carrier, the balance will be automatically be transferred to your credit card or the extended payment plan.

### *ITEMIZED RECEIPTS, aka. "SUPERBILLS"*

*Our fees and charges are based on the cost of doing business and providing patients with the highest quality of care possible. This office does not participate with any insurance provider or accept such an assignment. Patients are responsible for payment of any services provided. You will be given a receipt with a description of services received, more commonly referred as a "superbill", along with the related charges that you, in turn, can submit to your own insurance company for possible reimbursement, as well as retain for your personal records.*

### DECLARATION

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The doctor's office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account. **I understand that the office reserves the right to charge me for an office visit minimum of \$75.00 for which I do not show up or give a 24 hour cancellation notice for any chiropractic adjustment or consultation.** I also understand that the office reserves the right to charge a finance charge of 1 ½ % each month on bills past 30 days and that I will be sent to collections on bills past 60 days. I understand that there is a \$40.00 charge for all returned checks, and that all payment is due upfront, or at the agreed upon timing according to the paperwork signed by me at the time of my financial consultation.

I understand there could be some services that my insurance company does not cover, if this is the case are you willing to pay for these services?  Yes  No

## HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

## **HIPAA *continued...***

### **Use and Disclosures of Protected Health Information:**

Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.**

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Signature of Person Authorizing Care:

\_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Relationship to Insured \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Employer \_\_\_\_\_

**Primary Insurance Company** \_\_\_\_\_ **Policy#** \_\_\_\_\_

Address \_\_\_\_\_ Phone # (     ) \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insured's Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

