Athlete's Touch Massage Therapy

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Patient's Consent To Use Health Care Information:

I. Consent to use Health Care Information

I, _____, consent to allow Doiron Chiropractic & Sports Rehabilitation to use my health care information for purposes of treatment, and payment. I have been given a copy of Doiron Chiropractic & Sports Rehabilitation's, Notice of Privacy Practices and I acknowledge that I have been advised of my right to review the Notice prior to signing this consent. I am aware that the terms of the Notice may change, and that I may obtain a revised Notice at any time by contacting Doiron Chiropractic & Sports Rehabilitation. I understand that although I may request restrictions on the use of my information for treatment or payment and those restrictions will be binding if accepted by Doiron Chiropractic & Sports Rehabilitation. It
is Doiron Chiropractic & Sports Rehabilitation's policy not to accept such restrictions unless, in its sole discretion, a compelling reason exists to do so. I understand that I have the right to revoke this consent in writing, except to the extent that Doiron Chiropractic & Sports Rehabilitation has already taken action in reliance on it.

II. Consent to Treatment

I authorize Doiron Chiropractic & Sports Rehabilitation, its health care practitioners, staff, and other individuals involved in my health care to examine me and perform any tests, procedures and/or treatments that may be helpful. I understand that the healthcare provider responsible for this care will explain any proposed procedures or treatments, including their usual and most common risks and hazards. I also understand that I have the right to refuse any proposed procedure of treatment.

III. Authorization for Billing and Payment

I understand that I am responsible for paying all costs associated with my care and treatment. If I have health insurance, I understand that I am financially responsible in the event that some or all payment is denied by my insurance carrier or other third party payer. I am also responsible for charges not covered by my insurance such as deductibles, co-pays, or full payment for non- covered services. I authorize my health insurance carrier(s) or other third parties that are responsible for paying for my care to make payment directly to Doiron Chiropractic & Sports Rehabilitation

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This authorization to disclose will remain in effect for all subsequent exchanges of health care information for the limited purposes outlined above for 30 months from this authorization, unless I revoke it in any manner described below.

Should you wish to have a copy of this authorization, please ask the office staff

_____ Date_____

Signature of Patient, Parent, or Legal Guardian