

Patient Name: _____

Please fill in all Sections that apply to you:

Authorization—PLEASE READ BEFORE SIGNING

To process my medical claims for payment, I _____, hereby authorize Eshbaugh Chiropractic or their authorized agents, to release copies of my medical records and/or provide information regarding my physical or mental condition and treatment rendered to my insurance carrier and/or any agent acting on the insurance carrier’s behalf.

I also authorize Eshbaugh Chiropractic to release copies of my medical records to my primary care, family or other treating physicians.

I understand that if this is a workers’ compensation claim the carrier may employ a rehabilitation or consulting firm to handle my case. I authorize the release of my medical records to the workers’ compensation carrier and/ or rehabilitation or consulting firm.

I hereby assign to Eshbaugh Chiropractic all payments for medical services rendered to me and/or my dependents, and I understand and agree that any services not covered by my insurance carrier are my financial responsibility.

Signature of patient/parent/ legal guardian: _____

Printed Name: _____ Date: _____

**RECEIPT OF NOTICE OF PRIVACY PRACTICE
(HIPPA)
WRITTEN ACKNOWLEDGEMENT**

I, _____, have been made aware of HIPPA, understand, and am in agreement to Eshbaugh Chiropractic’s Notice of Privacy Practices regarding HIPPA.

Signature of Patient/ Legal Guardian Date

CONSENT TO TREAT A MINOR

I hereby authorize Dr. Daren Eshbaugh, D.C. and whomever he may designate as an assistant, to administer care as deemed necessary to treat my child _____.

Minor’s Name (printed): _____

Parent/ Guardian Signature: _____

Parent/ Guardian Printed Name: _____