

SHERWOOD FAMILY CHIROPRACTIC CLINIC

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20508 SW Roy Rogers Rd C115
Sherwood, OR 97140
503-906-3585

AUTHORIZATION FORM AND HIPAA REGULATIONS

This certifies that I have read and understand the information offered to me to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to my child or myself during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I UNDERSTAND THAT MY CHIROPRACTIC INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

I ALSO CERTIFY THAT I HAVE BEEN OFFERED OR READ AND UNDERSTAND THE OREGON HIPAA REGULATIONS.

I am also aware that I can seek treatment from another health care provider for my current complaint if I opt to do so.

Signature of Patient (or legal guardian of a minor)

Date