Susan J. Schliff, DC
Myriam E. Marte-Velez, DC
Emily J. Marshall, DC
500 Helendale Road
Suite 260
Rochester, NY 14609

Informed Consent

Chiropractic care, like all forms of care, has potential inherent risks associated with its application. Your doctor will do everything to minimize the possibility of these occurrences, as patients' health and and well-being is a primary concern. Some of the risks in which we wish to make patients aware of are post-treatment soreness, physical therapy burns, fractures, sprains/strains, and strokes. If you have any questions or concerns regarding any of the above potential risks please do not hesitate to address them with your doctor.

Having read the above statement, I hereby give informed consent to receive care.

Patient/Legal Guardian Signature _____ *Date* _____

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The above act ensures a patient's right to privacy regarding personal health information and it is our office policy to maintain confidentiality to the highest degree with all patient information. A complete copy of the HIPAA is available from the reception desk upon your request. Please feel free to ask your doctor or office personnel regarding any questions or concerns.

By signing below, I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Insurance companies and business associates are covered entities under the HIPAA rules. From time to time your insurance company may request your medical information.

Patient/Legal Guardian Signature _____ *Date* _____

Office Policies

I agree to take full financial responsibility for my chiropractic care in the event that the assumed coverage (No Fault Insurance, HMO, etc.) is denied.

I further understand that the office charges a $20 fee for returned checks, and for appointment cancellations with less than 24-hour notice or for not attending a scheduled appointment.

I also understand that fee-for-service is required at the time of service or the office reserves the right to charge a $5 service fee.

Patient/Legal Guardian Signature _____ *Date* _____