PARADIGM CHIROSPORT
CERTIFIED CHIROPRACTIC SPORTS PRACTITIONER, ACBSP

PATIENT INFORMATION & CONSENT FORM

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship.

I clearly understand that all services rendered to me are charged directly to me and I am personally responsible for payment. Full payment is expected at the time of service, unless prior arrangements have been made. We will accept a check, cash or credit card. I also understand that if I terminate or suspend my care, any fees for professional services rendered to me will be due and payable within thirty days. **I also understand any canceled appointments made without a 24 hour notice or a "no-show" appointment will result in a $30.00 fee.** _____ **(patient's initials)**

I hereby instruct my insurance company to make direct payments to my doctor. I also authorize the release of any information pertinent to my case such as medical records and or reports to my insurance company, adjuster, or attorney involved. _____ **(patient's initials)**

I hereby request and consent to to the performance of chiropractic adjustments and other chiropractic procedures/services including various modes of physiotherapy on me (or on the patient's name below, to whom I am legally responsible) by the Doctor affiliated with Joe Houde DC. Occasionally comments about your symptoms and prognosis may be discussed during your visit with the potential of others to hear the dialog. _____ **(patient's initials)**

I understand in the practice of chiropractic care there are some risks to treatment, including, but not limiting to, fractures, sprains, disc injuries, and strokes. In addition, Graston Technique and Cupping are an instrument assisted soft tissue technique/treatment used to break up scar tissue. Graston Technique and Cupping may produce the following: Local discomfort during treatment, reddening of the skin, superficial bruising, and post treatment soreness. I don't expect the Doctor to be able to anticipate and explain all risks and complications. I wish to rely on the Doctor to exercise judgement during the course of the treatment, based on the history and facts then known is in my best interest. _____ **(patient's initials)**

I have read, or have had read to me the above consent. By signing the below I agree to the above and allow the Doctor affiliated with Joe Houde DC to perform such. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Signed this _____ day of _____, 2016

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____