INFORMED CONSENT

By signing this form, you are consenting to an examination and/or treatment by:

Theodore J. Martinez, D.C.
1782 E. Bullard Ave., Suite 102
Fresno, California 93710

Dr. Martinez employs standard chiropractic methods including but not limited to:

- Observation
- Inspection
- Auscultation
- Percussion
- Palpation
- Manipulation
- Ultrasound
- Sine Wave
- Hot/Cold Packs
- Traction
- X-rays
- Recommendation of orthopedic appliances, supports, devices, and bandages

I understand the above statement. I agree to the above procedures and accept the risks and consequences of their application.

Authorization and Release:
I understand and agree to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you **do not** want to receive your medical records, please print their name(s) here:_____.

I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 16% and 40% if the account is referred to a collection's agency.

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

_____ _____

Patient's or Guardian's Signature Date