

Queensbury Family Chiropractic

358 Quaker Road  
Queensbury, NY 12804  
(518) 798-1111

**RELEASES**

I hereby request and consent to receive chiropractic services, including, but not limited to, adjustments, various manual and mechanical procedures, various modes of therapy and X-rays, for me (or for the patient named below, for whom I am legally responsible) by any licensed Doctors of Chiropractic who now or in the future treat me while employed by, working with, are associated with, or providing coverage services for this office (collectively known as the "Treating Doctor(s)"), including those working at any office associated with the Treating Doctor(s) (collectively known as the "Staff".) I authorize the Treating Doctor(s) and Staff to request medical records as needed from any source. **Initials:** \_\_\_\_\_

I clearly understand that all services rendered me are charged directly to me and that I am personally responsible for payment. I authorize and assign any benefits to be paid directly to the Doctor's Office. Any payments will be immediately credited to my account upon receipt. I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered me will be immediately due and payable. **Initials:** \_\_\_\_\_

In consideration of services rendered, I hereby assign to the provider of the services and his assignees so much of my third party insurer, first party no-fault automobile or Worker's Compensation insurance benefits and rights, attendant thereto, as shall equal the full amount of the bill for such services and the provider or his assign may secure in my name. **Initials:** \_\_\_\_\_

Kindly furnish my doctors, insurance company, attorney and any other involved parties or their representatives all information you may have regarding my condition while under your treatment or observation, including but not limited to the history obtained, X-ray, testing, physical findings, diagnosis and prognosis. **Initials:** \_\_\_\_\_

I have had the opportunity to review and understand a Privacy Notice. I understand that I have the right to review the complete policy prior to signing this consent. I understand that the organization reserves the right to change their notice and practices. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. There are no restrictions, unless explicitly noted here. **Initials:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**I have read and understood the above information:**  
  
**Patient Name:** \_\_\_\_\_  
  
**Patient/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_