



Buckeye Health & Rehabilitation  
**CONSENT/RELEASE RECEIPT**

**CONSENT FOR TREATMENT:**

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician(s) and/or licensed physical therapist and it is the responsibility of the staff to carry out the instructions of such physician(s) and/or licensed physical therapist. I hereby authorize Richard L. Van Voorhis, D.C., Tara J. Horner - Van Voorhis, P.T., Theresa M. Chambers, P.T., or any Licensed D.C. and/or P.T. employed by Buckeye Health & Rehabilitation and whomever they may designate as his/her assistants to administer treatment as he/she deems necessary to my child (who I am certifying is a minor).

**RECEIPT OF FINANCIAL POLICY ACKNOWLEDGEMENT:**

I hereby acknowledge that I received, read, and understand the Financial Policy, and agree to all conditions set forth within this policy. Buckeye Health & Rehabilitation's Financial Policy has been explained to me and I understand it fully. I understand that I am fully and ultimately responsible for my bill in the event that my insurance company, worker's compensation, auto insurance, etc. denies payment for any reason.

**RECEIPT OF AUTHORIZATION OF SERVICE/RELEASE OF INFORMATION TO PROFESSIONAL IMAGING CONSULTANTS, INC. (PIC) ACKNOWLEDGEMENT:**

I hereby acknowledge that I received, read, and understand the Authorization of Service/Release of Information to Professional Imaging Consultants, Inc. (PIC), and agree to all conditions set forth. This Authorization has been explained to me and I fully understand it. I also understand that my x-rays are being sent to Professional Imaging Consultants, Inc. (PIC) for interpretation and a written report by a board certified chiropractic radiologist. I understand that PIC will bill my insurance carrier and/or attorney for this service and that I am responsible for any unpaid balance. I understand that I am fully responsible for my bill in the event that my insurance company, worker's compensation, auto insurance, etc. denies payment for any reason whatsoever.

**RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT:**

I hereby acknowledge that I received, read, and understand the Notice of Privacy Practices of Buckeye Health & Rehabilitation, which sets forth the ways in which my personal health information may be used or disclosed by Buckeye Health & Rehabilitation and outlines my rights with respect to such information.

**RELEASE OF INFORMATION:**

By signing this form, you are granting consent to Buckeye Health & Rehabilitation to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our offices at (740) 798-8551. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

**MEDICARE AND MEDICAID CONSENT TO RELEASE INFORMATION:**

I certify that the information given by me in applying for payment under Title XVIII and / or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim.

**RECEIPT OF FINANCIAL HARDSHIP PROGRAM/POLICY ACKNOWLEDGMENT:**

I hereby acknowledge that I received, read, and understand the Financial Hardship Program/Policy, and agree to all conditions set forth within this program/policy. Buckeye Health & Rehabilitation's Financial Hardship Program/Policy has been explained to me and I understand it fully. I am also acknowledging receiving, reading, understanding, and filling out to the best of my knowledge accurate information on the financial Hardship Application.

**RECEIPT OF INFORMED CONSENT ACKNOWLEDGEMENT:**

By signing this form, I hereby acknowledge having received, read, and understand the Informed Consent (Doctor-Patient Relationship in Chiropractic), and hereby hold the doctor liable for only the diagnosis of the VSS and VSC.

**TIME OF SERVICE POLICY:**

In an effort to keep our office cost low by saving time and paper work, we offer all of our patients a time of service (TOS) discount and TOS packages. All patients are offered these discounts and packages and have the opportunity to take advantage of these savings.

\_\_\_\_\_ I accept the TOS discounts or TOS packages and to the terms here stated.

\_\_\_\_\_ At this time I decline the TOS discount or TOS packages and would like my insurance carrier billed for my services rendered.

By signing this form, I hereby acknowledge having read and understood this Policy as described above, and it has been explained to me and I understand it fully. I also have been shown the TOS discounts and TOS packages that this office offers.

**VERIFICATION OF NON-PREGNANCY OR PREGNANCY (Female Patients Only):**

By my initials on this line: \_\_\_\_\_, I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period: \_\_\_\_\_.

By my initials on this line: \_\_\_\_\_, I do hereby state that to the best of my knowledge, I am pregnant or suspect to be pregnant at this time. Date of last menstrual period: \_\_\_\_\_.

Patient's Signature (Guardian's Signature if Minor): \_\_\_\_\_ Date: \_\_\_\_\_

Witness' Signature: \_\_\_\_\_ Date: \_\_\_\_\_