



Consent to Examine/Treat/Insurance Authorization

I, _____, give consent to be examined and treated by the team of specialists at Spinal Rehab and Wellness Center. I have been informed of the examination findings and proposed treatment plan and give him/her informed consent for treatment to be initiated as of the date below. I understand the risks and benefits of chiropractic care and allow treatment. I give authorization of SRWC to contact my insurance company for treatment received at SRWC. Insurance information provided by the patient is solely used for the purpose of repayment of treatment being rendered. I understand that my insurance may not cover the cost of treatment fully. I am liable for treatment costs not covered by my insurance company (co-pays, deductible, other services not covered by insurance). All information provided by the patient is confidential and will not be misused. SRWC is HIPAA compliant and abides by its regulations.

Signature of Patient

Date

We would like to keep you updated on the progress of your treatment along with sending you tailored exercise and stretches for your treatment. Your email address is solely confidential to Spinal Rehab and Wellness Center.

Email Address: _____