Please read and initial each of the following statement, as well as sign and date where indicated below.

Appointment Reminders and Health Care Information Authorization

_____ Dr. Kiefat and members of the staff at Heartland Clinic of Chiropractic may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home or do not answer, a message may be left on your answering machine or voicemail. By signing this form, you are giving us authorization to contact you with these reminders and information.

Authorization to Release Information

_____ I authorize Heartland Clinic of Chiropractic to release all information related to the care I receive, to my HMO, insurance company, third party payer or their designee, as may be necessary for the payment of my bill, determining benefits or for utilization and quality review purposes.

Information about Possible Risks of Treatment

_____ Doctors of Chiropractic, Medical Doctors and Physical Therapists using manual therapy treatments for their patients with headache and cervical spine (neck) complaints, are required to explain that there have been rare cases of injury to a vertebral artery as a result of treatment. Such and injury has been known to cause a stroke, sometimes with serious neurological damage. The chances of this happening are estimated to be approximately from 1 per 400,000 treatments to 1 per 10 million treatments.

Appropriate tests will be performed to help identify if you may be susceptible to this type of injury; you will be notified if that is the case. If you have any questions about this, please do not hesitate to speak with your Doctor of Chiropractic.

As with any health procedure, complications may arise during treatment. These complications include soreness, muscle or ligament strain, dislocations, fractures, disk injuries, or physiotherapy burns. These are extremely rare occurrences.

Consent for Treatment

_____ I authorize the performance of diagnostic tests, procedures and treatment deemed necessary by personnel involved in my care.

Assignment of Benefits

_____ I assign Heartland Clinic of Chiropractic all benefits payable to me for my care. I understand that this health care facility will be paid directly by the insurance company or other payer. The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

Guarantee of Payment

_____ I guarantee payment of all charges incurred for treatment in accordance with the rates and terms of this health care facility.

______________________________	______________________________
Printed Name of Patient	Printed Name of Parent/Guardian & Relation
______________________________	______________________________
Patient/Parent/Guardian Signature	Date
______________________________	______________________________
Witness Signature	Date