1601 Carmen Drive, Suite 112
Camarillo, CA 93010
www.drcoffmanchiro.com
(805) 383-9114

I consent to have my doctor communicate with me through potentially nonsecure methods like email, Social Media, Videocall/FaceTime, and/or Text message (SMS), etc.. Your doctor will not publicly divulge information about you via these services, but by checking this box, you allow for the rapid responses that are inherent to their nature. Our patients find it quite useful for simple questions, scheduling, and account notifications.

☐ _____ **Initials**

I have read the office policies & scheduling guidelines in response to COVID-19 and agree to the terms, including to self-screen prior to each appointment and will cancel/reschedule my appointment when I do not meet the guideline requirements. I understand that there is no guarantee to prevent transmission of COVID-19 (or other illnesses) and will not hold Coffman Chiropractic liable if I become ill as I am voluntarily choosing to receive chiropractic care.

☐ _____ **Initials**

CANCELLATION & NO-SHOW POLICY **(updated in response to COVID-19)**

Coffman Chiropractic has a 24-hour cancellation policy. If you are unable to make your appointment, please contact our office as soon as possible to reschedule.
There is a **$35 fee** for all appointments that are not rescheduled more than 24-hours in advance; however, for any same-day cancellations (non-illness related), missed appointments or if you need to be rescheduled due to your late arrival or non-compliance with the new guidelines (show up sick, etc.) you will be **charged a $55 fee or the full rate of your appointment** (honoring fee rates set by contracted insurance companies when applicable). Please arrive 5 minutes early to your appointment. Thank you for your understanding!

☐ _____ **Initials**

ASSIGNMENT AND RELEASE (insured patients)

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.
I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

_____

Patient Signature & Date
(or Patient Guardian/Parent/Representative)

COFFMAN CHIROPRACTIC

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Chiropractic Informed Consent To Treat

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below/or other licensed doctor of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed, and there is no promise of a cure. I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I don't expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but are not limited to, self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns to the nature of my symptoms and treatment options.

I have read or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Chiropractor Name: Brent Coffman, D.C.

_____

Patient Signature & Date
(or Patient Guardian/Parent/Representative)