Dr. Aleksander Kanevsky
845 3rd Avenue, 20th Floor
New York, NY 10022
Tel: (212) 888-0520

ATLANT CHIROPRACTIC

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Consent and Terms of Acceptance

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.
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 other procedures. I understand that results are not guaranteed.
I 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 do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

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) f)or which I seek treatment.

The Chiropractic goal is to eliminate misalignments within the spinal column. It is important that each patient understands both the objective and the method that will be used to attain this goal. This will help prevent any confusion or disappointment. I do not offer to diagnose or treat any other diseases or conditions other than vertebral subluxation. However, if during the course of a chiropractic spinal examination I encounter non-chiropractic or unusual findings, I will advise you. If you desire advice, diagnosis or treatment or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others.

I, ____ have read and fully understand the above statements.
(Print Name)
All questions regarding the Doctor's pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

____

(Signature Required) *(Date)*

Consent to evaluate and adjust a minor

I, ____being the parent or legal guardian (Signature of Consenting Parent or Legal Guardian) (Date)

Of ____have read and fully understand the terms of acceptance and hereby
(Name of under age patient)
grant permission for my child to receive chiropractic care on this basis

Acknowledgement of Notice of Privacy Practices

I, __________________________________, have been presented with a copy of the Notice of Privacy Practices for the office of Dr. Aleksander Kanevsky, detailing how my information may be used and disclosed as permitted under federal and state law.

***Signed:** X_______________________________________ **Date:** _____________**Relationship to Patient:** ___________________________________*

ASSIGNMENT OF INSURANCE BENEFITS

Benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits for services rendered or for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I hereby authorize insurance to pay and hereby assign directly to Atlant Chiropractic, P.C. (Aleksander Kanevsky, D.C.), all benefits if any, otherwise payable to me for his services as described on claims forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by me and paid to Atlant Chiropractic, P.C. (Aleksander Kanevsky, D.C.), will be credited to may account, with accordance with the above said assignment. I hereby agree and understand that if I receive payment from my insurance company for services rendered by Atlant Chiropractic, P.C. (Aleksander Kanevsky, D.C.), I am to indorse the check and mail with statement to his office. I clearly understand that it is still my responsibility to make sure the bill is paid in a reasonable time. If for any reason any portion of my bill is not paid by my insurance, I further agree to make arrangements for prompt payment of the bill. I acknowledge and understand the fact that if for some reason I fail to submit payment on my account and my account is being reported to a collection agency, collection fee of 20% of the balance will be added to my account.

***Patient's Name**____**Signature**______________________________________**Date**________________*