



**CONFIDENTIAL
HEALTH INFORMATION**

All information you supply is confidential. We
comply with all federal privacy standards.

Advanced Back Solutions
Dr. Kevin Venerus
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(734) 437-7689

Assignment of Insurance Benefits and Authorization to Release Information

Payment is required at the time of service unless prior arrangements are made. I hereby authorize direct payment of medical benefits to Dr. Kevin Venerus for services rendered by him. I understand I am responsible for any balance not covered by my insurance carrier, workers comp, or auto carrier. I hereby authorize Dr. Venerus to release any medical information that may be necessary for either medical care or in processing applications for financial payment. By signing this, I understand that I am agreeing that either my physician or his staff have gone over with me, and answered all my questions regarding this notification.

Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of disc condition, and rarely fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care in this chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health, and in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, and related modalities.

Patient Signature (Legal Guardian)

Date

Witness Signature (Office Staff)

Date