Neal Wieder, DC, DCBCN **1045 Primera Blvd, Ste. 1017, Lake Mary, Florida 32746**
FAX: 407-915-6853 PHONE: 407-682-4454

GENERAL CONSENT FOR TREATMENT

I understand that all recommendations and treatment modalities used by this office are solely to promote optimum health and wellness with either Chiropractic care, Acupuncture and or Nutritional care. Chiropractic care helps to re-align misaligned vertebrae to assist the body with relieving related symptoms and help to restore the body to a better state of health. Other therapies may be used along with chiropractic care such as exercise rehabilitation, ultrasound, Electrical Muscle Stimulation, manual muscle therapy (myofascial release) hot or cold, infrared, traction or exercise, or laser therapy. Nutritional care is designed to help the body with any nutritional deficiencies that are determined. Nutritional supplements for nutritional deficiencies and changes in my diet may be suggested by Dr. Neal Wieder for my personal use. Acupuncture is designed to help either increase or decrease circulation (Chi) to different parts of the body using sterilized acupuncture needles, laser acupuncture, electric acupuncture, cupping and or Moxibustion (heat). The benefits and risks will be discussed with me, and, I understand that the treatment recommended is not intended or implied to be a cure for acute or chronic disorders or disease, which may require monitoring by my primary care physician. I understand that X-rays, MRI's or other diagnostic testing may be recommended and necessary for my care and treatment. I am also aware that the recommendations made by this office are designed to supplement traditional methods of treatment. The chiropractic physician and professional staff of the Dr. Neal Wieder, will not offer these treatments to me except under the condition that I have read and signed this consent for treatment form. I further understand that I may ask any questions I may have about the treatment rendered and that the treating physician or staff will gladly answer them.

I HAVE READ AND UNDERSTAND THE ABOVE and under the conditions indicated, I hereby place myself/or minor child under the care of Neal Wieder, DC, DCBCN and staff and request treatment.

X_____ X_____ _____
PRINTED NAME/PATIENT/MINOR CHILD SIGNATURE/PATIENT/GUARDIAN DATE

AUTHORIZATION TO OBTAIN, RELEASE OR REVIEW PROTECTED HEALTH INFORMATION (PHI)

Patient Name_____ ID Shown:_____ Social Security #: XXX-XX-_____
Address: _____
Date of Birth: ___/___/_____ Phone: _____ Date of Service (s):_____
I hereby authorize:_____
Address: _____ Phone:_____ Fax: _____

___ To Release to ___ To Obtain from:
TO SEND RECORDS TO:
Neal Wieder, DC, DCBCN – 1045 Primera Blvd, Suite 1017, Lake Mary, Fl. 32746

FAX RECORDS TO: 407-915-6853 PHONE: 407-682-4454

The following information contained in my medical record regarding my care, treatment or hospitalization:

___ Complete Record ___ All Diagnostic Test Results ___ Pathology Report(s)
___ Radiology Reports ___ Consultation(s) ___ Laboratory
___ Progress Notes ___ Operative Report(s) ___ Other: _____

The purpose for the release of my Personal Health Information (PHI) is for:
___ Continued Treatment ___ Insurance ___Legal Action ___ Personal Use ___ Other: _____

May **NOT** include information related to: __ HIV/AIDS __ Mental Health __ Drug/Alcohol Abuse __ Genetic Counseling (Initial)

I understand that this authorization extends to all or any part of the records designated above. I expressly consent to the release of the information as designated above as required by applicable laws. This authorization shall expire in one year. I understand that this authorization is revocable upon written notice to this office. I further understand that my PHI that is used or disclosed under this authorization may no longer be protected by law. I further understand that Neal Wieder, DC, DCBCN may not condition the provision of treatment, payment, enrollment in a health plan or eligibility for benefits on the provision of this authorization. I understand that I will receive a signed copy of this form, if I opt to request one.

_____ _____
SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE OR PARENT/LEGAL GUARDIAN Date

_____
PRINTED NAME OF PATIENT/LEGAL REPRESENTATIVE OR PARENT/LEGAL GUARDIAN
___ I wish to revoke this authorization. SIGNATURE: _____