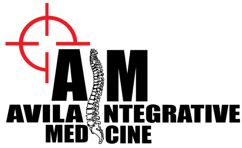

CONSENT FOR TREATMENT/ AUTHORIZATION FOR RELEASE OF INFORMATION FOR MEDICAL RECORDS

All references herein to Doctor mean and include Avila Integrative Medicine and AIM Pediatric Therapy. All references herein to "Patient" mean and include the patient and any other person acting on behalf of the patient.

The patient is:____

PATIENT ACKNOWLEDGES THE READING OF THIS AGREEMENT, THAT IT HAS BEEN FULLY EXPLAINED, AND THAT IT IS FULLY UNDERSTOOD REGARDING CONTENTS, HAS RECEIVED A COPY THEREOF, AND THE PATIENT, OR A PERSON DULY AUTHORIZED TO EXECUTE THIS AGREEMENT AND ACCEPT ITS TERMS.

Insured/Patient Signature:________________________________ Date:___________________

Witness:____

If the patient is a minor or for any reason is unable to consent because of physical disability or incompetence, complete the following:

The patient is unable to consent because:____

Person with Authority to Consent for Patient:____

Relationship:_____________________ Witness:______________________________________

- **Chiropractic, Massage Therapy, Physical Therapy, Speech Therapy, Occupational Therapy Care, ABA Therapy Consent:** The patient who is suffering from a condition requiring Chiropractic and/or Therapy treatment does hereby voluntarily consent to and authorize such care with diagnostic services, including but not limited to x-ray and/or non-invasive procedures, which may be performed under order from Dr. Robert J. Avila, D.C., CCST, CCCN, Licensed Therapists, assistants or designee as is necessary in their judgement.
- **No Guarantee:** I am aware that the practice of chiropractic, massage therapy, physical therapy, speech therapy, and occupational therapy are not an exact science and I acknowledge that no promises or guarantees have been made to me as to the results of treatment to be provided for me by the assistant or my physician.
- **Assignment of Benefits:** I authorize and direct the Insurance Company(s) to pay directly to Avila Integrative Medicine, all insurance benefits otherwise payable to me. I understand that I am financially responsible to Avila Integrative Medicine for charges not covered by or paid pursuant to this authorization.
- **Medicare:** Patient certified that the information provided in applying for payment of changes for health care and the services of certain physicians for whom the health care facility is authorized to bill in connection with its services under Title XVIII or Title XIX of the Social Security Act is correct. Patient requests payment of authorized benefits under the Social Security Act to be made to Avila Integrative Medicine on behalf of the patient and authorizes the release of all medical records of the patient required to act on this request and agree that for such purpose a copy of this agreement may be used in place of the original. Patient hereby assigns to Avila Integrative Medicine is authorized to bill in connection with its services.
- **Release of Information:** I hereby authorize Avila Integrative Medicine, AIM Pediatric Therapy to disclose, as necessary to substantiate claims, any or all parts of my medical records to any person or corporation, which is or may be liable under a contract for all or part of the charges, including but not limited to, my insurance company, any third party payer, provider of services, medical service companies, employer, workman's compensation carrier, welfare agency, social agency, or government agency. I further authorize the release of medical records and medical information to facility personnel for the purpose of treating my condition and protecting facility personnel and other patients from contagious or communicable disease or illness. Information released is done so in compliance with State and Federal Laws.
- **Financial Agreement:** In consideration of the services to be rendered to patient and all other persons signing this agreement, jointly and severally, agree to pay (I) in full, all costs, charges and expenses of Avila Integrative Medicine, AIM Pediatric Therapy of every kind and description for service, supplies, vitamins, and other items supplied or furnished by Avila Integrative Medicine, AIM Pediatric Therapy to or for the benefit of the patient, and (II) all costs of collections, including reasonable attorney fees, and agree that a copy of this Agreement shall be as effective and valid as the original.

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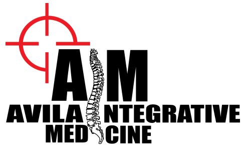

Attendance Policy

We require a 24 hour notice for all cancelled appointments

1st and 2nd cancel/ no show appointment with no reschedule we will attempt to call you to reschedule
3rd cancel/ no show appointment with no reschedule we will attempt to call you to reschedule or send a letter to contact our office to reschedule.

Final cancellation with no reschedule will result in a discharge from care.

I, ________________________, agree to the attendance policy provided by Avila Integrative Medicine, AIM Pediatric Therapy.

Patient Signature:_______________________________ Date:__________________________

Witness:_______________________________________ Date:__________________________

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