



**Stibbard Chiropractic**  
6975 Wyandotte St. E,  
Windsor, On, N8S 1P8  
Phone: (226) 506-2681  
[stibbardchiropractic@gmail.com](mailto:stibbardchiropractic@gmail.com)  
[stibbardchiropractic.com](http://stibbardchiropractic.com)

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Gender:    Male    Female    Other: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Relationship: \_\_\_\_\_

Medical Dr. Name: \_\_\_\_\_ Date of last physical: \_\_\_\_\_

Previous Chiropractor Name: \_\_\_\_\_

Permission to Contact above health care providers:    Y    N

How did you hear about our clinic?: \_\_\_\_\_

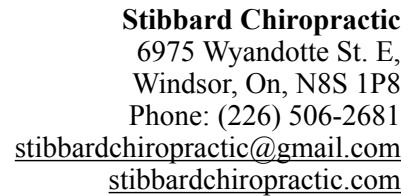
Private Insurance Provider: \_\_\_\_\_

Policy #: \_\_\_\_\_ Member #: \_\_\_\_\_

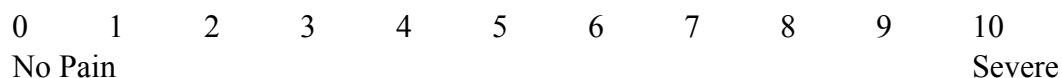
Name of card holder: \_\_\_\_\_

Relationship to card holder: \_\_\_\_\_

Is this a workplace injury or a motor vehicle accident?: \_\_\_\_\_ Claim Number: \_\_\_\_\_



Dull Pain = D  
Stiffness = S





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Please check the appropriate box for any of the following symptoms, which you have now or have had previously

**C = Constant**

**F = Frequent**

**O = Occasional**

<b>NEUROLOGICAL</b>	<b>C</b>	<b>F</b>	<b>O</b>
Allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neuralgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tremors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>MUSCLE AND JOINT</b>	<b>C</b>	<b>F</b>	<b>O</b>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bursitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foot Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>RESPIRATORY</b>	<b>C</b>	<b>F</b>	<b>O</b>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spitting Blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Throat Phlegm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>EYES, EARS, NOSE AND THROAT</b>	<b>C</b>	<b>F</b>	<b>O</b>
Colds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deafness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental Decay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear Aches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear Noises	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>EYES, EARS, (CONTD)</b>	<b>C</b>	<b>F</b>	<b>O</b>
Sinus Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enlarged Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enlarged Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Failing Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Far Sighted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gum Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nasal Obstruction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Near Sighted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>CARDIO-VASCULAR</b>	<b>C</b>	<b>F</b>	<b>O</b>
Rapid Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Slow Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swelling of Ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hardening of Arteries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain Over Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor Circulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>GASTROINTESTINAL</b>	<b>C</b>	<b>F</b>	<b>O</b>
Excessive Hunger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burping or Gas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficult Digestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distension of Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gall Bladder Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intestinal Worms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting Blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>SKIN</b>	<b>C</b>	<b>F</b>	<b>O</b>
Boils	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hives or Allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin Rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>GENTO-URINARY</b>	<b>C</b>	<b>F</b>	<b>O</b>
Bed Wetting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urine Control Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pus in Urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smell of Urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>PAIN/NUMBNESS IN</b>	<b>C</b>	<b>F</b>	<b>O</b>
Shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Painful Tailbone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sciatica	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>FOR WOMEN ONLY</b>	<b>C</b>	<b>F</b>	<b>O</b>
Cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heavy Flow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Light Flow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Cycle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Painful Cycle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sore Breasts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Menopausal</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Last Menstruation Date:			
<b>Pregnant</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Due Date:			



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List of All Current Medications:

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Previous Chiropractic Care: \_\_\_\_\_

Allergies: \_\_\_\_\_

Surgeries: \_\_\_\_\_

Hospitalizations: \_\_\_\_\_

Infections: \_\_\_\_\_

Check all that apply- Do you have a family history of:

Cancer \_\_\_\_\_ Diabetes \_\_\_\_\_ High Blood Pressure \_\_\_\_\_ Heart Disease \_\_\_\_\_ Stroke \_\_\_\_\_

Arthritis \_\_\_\_\_ Other: \_\_\_\_\_

Check all that apply- Have you experienced any recent:

Unexplained weight loss \_\_\_\_\_ Fever or night sweats \_\_\_\_\_ Fatigue/Malaise \_\_\_\_\_

Loss of appetite \_\_\_\_\_ Night pain \_\_\_\_\_

Hours of Physical Activity per week: \_\_\_\_\_ If you're pregnant, how many weeks?: \_\_\_\_\_

If you smoke, how many cigarettes per day?: \_\_\_\_\_

If you drink alcohol, how many drinks per week?: \_\_\_\_\_



## CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

### INFORMED CONSENT FOR ACUPUNCTURE CARE

It is important for you to consider the benefits and risks and alternatives to the acupuncture treatment offered by your chiropractor and to make an informed decision about proceeding with treatment.

Acupuncture involves the insertion of small sterilized needles into specific locations on the skin surface. Other procedures related to acupuncture include moxibustion, cupping and electroacupuncture.

#### **Benefits**

Acupuncture and procedures related to acupuncture have been demonstrated to be a safe and effective form of treatment for a range of conditions including musculoskeletal complaints and pain.

#### **Risks**

The risks associated with acupuncture include minor bleeding and bruising, temporary pain and soreness, nausea, fainting, burns, infection, shock, convulsions, pneumothorax, perforation of internal organs, and stuck or bent needles.

#### **Please inform the chiropractor if you:**

- Have or develop any major health issues
- Are pregnant or actively trying to be
- Have been fitted for a pacemaker or other electrical implants
- Have a bleeding disorder or take anticoagulants
- Have damaged heart valves or have a high risk of infection
- Suffer from metal allergies
- Are Immune compromised
- Have had prosthetic implants

Only sterile single use disposable needles will be used. All acupuncture needles are properly disposed of after each and every treatment.

#### **Pregnancy**

The use of certain acupuncture points and treatment techniques may not be recommended during pregnancy. Advise your chiropractor if you are pregnant or actively trying to be.

#### **Alternatives**

Alternatives to acupuncture treatment may include rest, exercise, other modalities or consulting other health professionals.

#### **Questions or Concerns**

You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time. **Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition.**

#### **DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR**

I hereby acknowledge that I have read this form and discussed with the chiropractor the assessment of my condition and the treatment plan. I Understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to acupuncture treatment as proposed to me.

\_\_\_\_\_  
Name (Please Print)

\_\_\_\_\_  
Signature of Patient (or legal guardian)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Chiropractor

\_\_\_\_\_  
Date

## CONSENT TO CHIROPRACTIC TREATMENT

It is important to consider the benefits, risks and alternatives to treatment. This will help you make an informed decision about proceeding with care.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body. It also includes soft-tissue techniques, therapeutic modalities and exercise.

**Benefits** - Chiropractic treatment has been shown to be effective for complaints of the neck, back and other areas of the body related to nerves, muscles and joints. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility and improve function.

**Risks** - The risks associated with chiropractic treatment vary according to each patient's condition and the location and type of treatment. The risks include:

- **Temporary discomfort or worsening of symptoms** – Treatment may cause some discomfort or an increase in pre-existing symptoms of pain or stiffness. This can last a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur with the use of some types of electrical and light therapies. Skin irritation should resolve. A burn may leave a permanent scar.
- **Sprain or strain** – A muscle or ligament sprain or strain may occur. These should resolve within a few days or weeks with rest, minor care and/or protection of the affected area.
- **Rib fracture** – A rib fracture may occur. This can be painful and limit your activity for some time. These usually heal over several weeks with or without further treatment.
- **Disc injury or aggravation** – Some reported cases associate chiropractic treatment with injury or aggravation of a disc condition. This is rare. Spinal discs may degenerate with age or become damaged, with or without symptoms. Signs and symptoms may include neck and back pain, impaired mobility, or radiating pain and numbness into the legs or arms. In severe cases, impaired bowel or bladder function or impaired leg or arm function may occur, which may need surgery.
- **Stroke** – Some reported cases associate chiropractic treatment of the neck with stroke. This is rare. This type of stroke is a serious event involving arteries in the neck and the interruption of blood flow to the brain. The consequences of a stroke can include impairment of vision, speech, balance and brain function, as well as paralysis or death. If signs of stroke occur, seek medical attention immediately.

**Alternatives** - Alternatives to chiropractic treatment may include consulting other health professionals, over-the-counter pain relievers, rest, and exercise. Each may have their own benefits and risks.

**Questions or concerns** - Please ask questions at any time about your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time. You are encouraged to be involved in and responsible for your care. Inform your chiropractor immediately of any change in your health or condition.

I acknowledge that I have discussed my condition and the treatment plan with the chiropractor. I understand the nature of the treatment offered to me. I have considered the benefits and risks of treatment and the treatment alternatives. I have read this form or had it read to me. I consent to chiropractic treatment as proposed to me.

**Do not sign this form until you meet with the chiropractor.**

\_\_\_\_\_  
Patient Name (print)

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Chiropractor Signature



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#### **Accuracy of Information**

I certify that the above medical information is correct to my knowledge. \_\_\_\_\_ **Initial Here**

#### **Privacy & Sharing of Information**

I authorize the clinic and its associated health professionals to collect my personal and medial information as documented above. In addition, I authorize the clinic and its associated health professionals communicate with my family doctor and/ or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission. \_\_\_\_\_ **Initial Here**

#### **Cancellation Policy**

Your appointment time is reserved just for youj. A late cancellation of missed visit leaves a hole in the health professionals' day that could have been filled by another patient. As such, we require 24 hours notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours notice, or miss their appointment may be subject to cancellation fee. \_\_\_\_\_ **Initial Here**

#### **Direct Billing Consent Forms**

##### **Benefit Assignment Form**

I hereby assign benefits payable for the eligible claims to the Provider responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to the Provider. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the Provider for any services rendered and/ or supplies provided.

I acknowledge and agree that the insurer/plan administrator is under no obligation to accept this Assignment, that any benefit payment made in accordance with this Assignment will discharge the insurer/plan administrator of its obligations with respect to that benefit payment, and that in the event the benefit payment is made to me, the insurer/plan administrator will also be discharged of its obligation with respect to that benefit payment.

I understand that this Assignment will apply to all eligible claims submitted electronically by the Provider and that I may revoke it at any time by providing written notice to the insurer/plan administrator.

If I am a spouse or dependent, I confirm that I am authorized by the plan member to execute an assignment of benefit payments to the Provider. \_\_\_\_\_ **Initial Here**



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### **Consent to Collect and Exchange Personal Information**

#### **Message to the Plan member, Spouse and/or Dependent regarding Personal Information**

Personal information that we collect and disclose about you, and if applicable, your spouse and/or dependents, is used by the insurer and/or plan administrator and their service provider(s) for the purposes of assessing your claims, underwriting, investigating, auditing and administering the group benefits plan, including the investigation of fraud and / or plan abuse.

#### **Authorization and Consent**

I authorize my healthcare provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the above purposes.

I authorize the insurer and / or plan administrator and their service provider(s) to:

- use my personal information for the above purposes.
- exchange personal information with any individual or organization, including healthcare professionals, investigative agencies, insurers and reinsurers, and administrators of government benefits or other benefits programs when relevant for the above purposes.
- exchange personal information concerning any claims submitted with the plan member or a person acting on behalf of the plan member.
- exchange personal information for the above purposes electronically or in any other manner.

I understand that personal information may be subject to disclosure to those authorized under applicable law.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original, and may remain in effect for the continued administration of the group benefits plan.

In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning claims submitted, I acknowledge and agree that the insurer and/or plan administrator and their service provider(s) may use and disclose relevant personal information to any relevant organization including law enforcement bodies, regulatory bodies, government organizations, medical suppliers and other insurers, and where applicable my Plan Sponsor, for the purposes of investigation and prevention of fraud and/or plan abuse.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable under the group benefits plan, and the exchange of personal information with other persons or organizations, including credit agencies and, where applicable, my Plan Sponsor, for that purpose.

If the patient is a person other than myself, I confirm that the patient has given their consent to provide their personal information for the healthcare provider and the insurer and/ or plan administrator and their service provider(s) to use and disclose their personal information as set out above. \_\_\_\_\_ **Initial Here**