

Family Chiropractic Center

Consent for Treatment

I, the undersigned, a patient in this office, hereby authorize *Family Chiropractic Center* to administer treatment as necessary.

I also certify that no guarantee or assurance has been made to the results that may be obtained.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company, and that any amount authorized to be paid directly to this office will be credited to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment.

Patient's signature: _____ Date: _____ Witness: _____

Authorization to Release Medical Information

I authorize the release of any medical information necessary to process my insurance claim(s), and also certify that all insurance information given is correct and complete.

Patient's signature: _____ Date: _____ Witness: _____

Authorization for Benefits to Provider of Care

I hereby authorize the _____ Insurance Company/Insurance Administrator to pay by check and for it to be mailed directly to: *Family Chiropractic Center*, the expense benefits allowable, and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered, and I have agreed to pay, in a current manner, any balance of said professional charges. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

Patient's signature: _____ Date: _____ Witness: _____

Attorney Representation and Protection of Balance

I, the undersigned patient, am directing my Attorney _____ to pay any outstanding bills out of my settlement, and, in effect, protecting any such balance. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for the doctor's additional protection and consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment, but will require me to make payment on a current status.

Patient's signature: _____ Date: _____ Witness: _____

Consent for Treatment of a Minor

I, the undersigned, hereby authorize Family Chiropractic Center to administer treatment as necessary to my _____ (son/ daughter). Name: _____

Patient's signature: _____ Date: _____ Witness: _____