Patient # ________________

DEMYEN FAMILY CHIROPRACTIC

CONSENT FOR TREATMENT

I, the undersigned, a patient in this office, hereby authorize Demyen Family Chiropractic 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 me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collections from the insurance company. However, I clearly understand that all services rendered to me are charged directly to me and I am personally responsible for payment.

Patient's Signature: ____________________________ Date:______________ Witness: ____________

Printed Name: ____

CONSENT FOR TREATMENT OF A MINOR

I, the undersigned, hereby authorize Demyen Family Chiropractic to administer treatment as necessary to my son/daughter, ____.

Parent'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 claim that all insurance information given to this clinic 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: Demyen Family Chiropractic, the expense benefits allowable, and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered, and that 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: ____________