SPINE
CHIROPRACTIC
REHABILITATION AND WELLNESS

Authorization and Assignment

I authorize Spine Chiropractic Rehabilitation and Wellness to use or disclose my personal health information to carry out my treatment, to obtain payment from insurance companies and for health care operations such as quality reviews.

I authorize the direct payment of any sum I now or hereafter owe to Spine Chiropractic Rehabilitation and Wellness by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or to Spine Chiropractic Rehabilitation and Wellness based in whole or in part upon the charges made for services provided me by Spine Chiropractic Rehabilitation and Wellness.

I, the undersigned do hereby appoint Spine Chiropractic Rehabilitation and Wellness the authority necessary to endorse and cash my checks, drafts or money orders which are made payable to the undersigned or as co-payee with this clinic when said payments are due to services rendered on behalf of the undersigned by the clinic.

I understand that insurance verification and authorization does not guarantee payment. I understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fee or court costs required to collect my bill.

Patient's Name (Print): _____

Patient or Guardian's Signature: _____ Date: _____

Informed Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor affiliated with Spine Chiropractic Rehabilitation and Wellness.

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest.

I have read, or have had read to me, the above consent. By signing below I agree to the above, and allow the doctor, affiliated with Spine Chiropractic Wellness and Rehabilitation to perform such. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

Patient's Name (Print): _____

Patient or Guardian's Signature: _____ Date: _____