PATIENT NAME: ______________________________ **ACCOUNT #:** ___________________

CONSENT FOR TREATMENT:

I, the undersigned, a patient in this office, hereby authorize the doctors of Midway Chiropractic & Health Services to administer treatment as is 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 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 upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me, and that I am personally responsible for payment.

CONSENT FOR TREATMENT OF A MINOR:

I hereby authorize the doctors of Midway Chiropractic & Health Services to administer chiropractic care as he deems necessary to my _________________ (indicate relationship of child). (Name)_________________________

AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

I authorize the release of any medical information to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete. I understand that this office will not release any information for any other reason without written consent.

REQUEST FOR PAYMENT OF BENEFITS TO PROVIDER OF CARE:

I, hereby authorize the ___________________ Insurance Company to pay by check and for it to be mailed directly to: Midway Chiropractic & Health Services, the expense benefits allowable, and otherwise payable to me under my current policy, as payment towards the total charges for the 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.

CONSENT TO BILL:

I understand that I have received $________________ in services, in the way of exam and/or xrays. I understand that I have a $________________ deductible on my insurance. I understand that my first day charges may be billed to my insurance company and that I will be responsible for $___________________. This is due to my hardship with the amount of $_______________. I further understand that I will be responsible for $_____________ after having paid $37.00 for my first day charges of $_______________.

Patient Signature:____________________________________ Date:_____________________

Witness Signature:___________________________________ Date:_____________________