CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for the Center for Natural Health and Rehabilitation, Inc. to furnish chiropractic care and treatment to:
Patient name: _____
Which is considered necessary and proper in diagnosing or treating his/her physical condition.

PATIENT SIGNATURE _____
SIGNATURE OF GUARDIAN IF PATIENT IS A MINOR_____
PRINTED NAME OF GUARDIAN_____

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I, the undersigned, hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance and third party payors to Center for Natural Health and Rehabilitation, Inc. photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including Medical Records to secure payment.

PATIENT NAME:_____
PATIENT SIGNATURE _____
SIGNATURE OF GUARDIAN IF PATIENT IS A MINOR_____

FINANCIAL OBLIGATIONS POLICY STATEMENT

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. If your insurance carrier does not remit payment within sixty (60) days, the balance will be due in full from you. In the event that your insurance carrier requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance carrier. In the even your insurance carrier establishes an internal usual and customary fee schedule, you will be responsible for the difference remaining.

If any payment is made directly to you by your insurance carrier for services billed by us, you recognize an obligation to promptly remit same to the Center for Natural Health and Rehabilitation Inc. within two (2) weeks from date of receipt unless the bill has been paid in full by you.

The above does not apply for those patients that are considered Worker's Compensation. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

I understand and agree that if I fail to make payments for which I am responsible within sixty (60) days of billing, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees. Also, I understand and agree that eighteen percent (18%) interest will be added monthly to any bills left unpaid for more than one year.

I the undersigned, have read and fully understand the above information. I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT AS STATED ABOVE IN THE FINANCIAL OBLIGATIONS POLICY STATEMENT SECTION.

PATINET SIGNATURE OR SIGNATURE OF GUARDIAN DATE

PRINT PATIENT NAME PRINT GUARDIAN NAME