

**❖ CONSENT FOR TREATMENT**

I, the undersigned, a patient in this office hereby authorize Dr. Boczar/Leever (and whomever he/she may designate as his/her assistant(s) to administer treatment as is necessary. I also certify that no guarantee or assurance has been made as 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 ant necessary reports and forms to assist me in making collection from my insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. 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.

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 to this clinic is correct and complete.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_

**❖ REQUEST FOR PAYMENT OF BENEFIT 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 Health Chiropractic, Inc. any 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 remaining balance for professional charges. Although our office will verify, we cannot guarantee accuracy of the quotes.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_

**❖ ATTORNEY REPRESENTATION AND PROTECTION OF BALANCE**

I, the undersigned patient, am directing my Attotney \_\_\_\_\_ 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/her 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 basis.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_

**❖ CONSENT FOR TREATMENT OF A MINOR**

I hereby authorize David Boczar, D.C. and/or Jenni Leever, D.C., to administer chiropractic care, as he/she deems necessary to \_\_\_\_\_.

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_