

Patient # _____

DEMYEN FAMILY CHIROPRACTIC

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.

Parent'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.

Parent'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.

Parent's Signature: _____ Date: _____ Witness: _____