BENNION CHIROPRACTIC

Whole Body Wellness for the Whole Family

CONSENT TO TREAT

Chiropractic care is a non-surgical, non-invasive procedure and has one of the safest records in health care. As with any health care specialty, we cannot promise a cure but we will discuss any questions or concerns with you. Patients may experience temporary symptoms such as an increase in soreness following a massage, manipulation or traction. In addition, physiotherapy such as ice, heat or ultrasound may irritate the skin. There have been a few cases where the adjustments may have aggravated a bulging or herniated disc or caused a rib fracture. On extremely rare occasions, adjustments to certain areas of the cervical spine have been related to a compromise of the vertebral artery and possible stroke symptomatology. I acknowledge that I have discussed non-surgical chiropractic care and physiological therapeutics and I authorize Bennion Chiropractic to provide such care.

ASSIGNMENT AND RELEASE

I authorize payment of insurance benefits directly to Bennion Chiropractic. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that I am responsible for all costs of chiropractic care, **regardless of insurance coverage**. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. By signing this document, I hereby authorize my physician, Clinton A. Bennion, D.C., or any of his employers, employees or agents (collectively "Physician") to release protected health information relating to my medical treatment by Physician, including information relating to the dates of my treatment and Physician's charges for my treatment (collectively "PHI"), which is reasonably necessary for Physician to be compensated for services provided to me. I authorize Physician to release my PHI to any person or entity responsible for paying for my care, to my attorneys (if I am being represented as a result of being injured in an accident) or as may be necessary to file a health care provider lien as permitted by state law.

OFFICE POLICIES

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made. As a courtesy to you, we will *usually* bill your insurance company and you are ultimately responsible for all fees incurred as a result of any treatment you receive in this office. If your account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred collecting your account. *If* your insurance company is billed and they deny payment, you authorize the treating doctor to file with small claims court on your behalf, against your insurance company, as a method of collection. You also agree to be present at the court date if needed. *If* your insurance company is billed and they send a check(s) to you that cover services rendered in this office, you agree to deliver that check and any associated paperwork to this office within **14** days of receipt. You also authorize the doctors and staff to act as your agent to endorse or to sign your name on any checks, drafts or money orders for payment of your bill for medical services rendered. *If* this was a result of a motor vehicle accident, your health insurance may not cover specific treatments that may be beneficial in your case. We reserve the right to collect our usual and customary fees for services rendered during your treatment. We also reserve the right to bill any and all insurance carriers that may be responsible for providing coverage. You authorize the staff to perform any necessary services needed during diagnosis and treatment.

You understand that if you miss a scheduled appointment without giving 12 hours notice, a fee of $25 will be billed directly to you.

You understand that if a credit card or debit is returned, you will be charged a $25 service fee.

In accordance with all stated above, I hereby understand and agree to the above stated information.

Signature _____ Date _____