Center for Natural Health and Rehabilitation

Patient Name: _____

Patient DOB: _____/_____/_____

Informed Consent & Financial Form

I, the undersigned, do hereby agree and give my consent for the Center for Natural Health and Rehabilitation, LLC (CFNH). to furnish chiropractic care and treatment to the above patient.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or on the patient named above, for whom I am legally responsible) by the doctor, affiliated with Center for Natural Health and Rehabilitation, LLC. I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor or CA to exercise judgment during the course of the procedure, which the doctor feels at the time, based on the facts then known, is in my best interest.

HIPAA / NOTICE OF PRIVACY PRACTICE

I understand that my health information is private and confidential. I understand that CFNH strives to protect my privacy and preserve the confidentiality of my personal health information. I understand that by signing this document, CFNH may use and disclose my personal health information to help provide health care to me, to handle billing and payment and for other health care operations. Failure to sign this document may result in the CFNH declining to treat me. I understand and I am aware of the practice's Notice of Privacy Practice. I am aware that my name may be visible to other patients on the office sign-in sheet and in certain clinical areas.

FINANCIAL OBLIGATIONS POLICY STATEMENT

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, LLC. A photocopy of this assignment is to be considered as valid as the original.

CFNH will bill my health insurance and/or auto insurance carrier solely as a courtesy. I am solely responsible for the entire bill when the services are rendered. I hear by attest that I am aware of my health insurance benefits and obligations towards any deductible, coinsurance and/or copayments. If my insurance carrier does not remit payment within sixty (60) days, the balance will be due in full by me. In the event that my insurance carrier requests a refund of payments made, I will be responsible for the amount of money refunded to my insurance carrier. In the event my insurance carrier establishes an internal usual and customary fee schedule, I will be responsible for the difference remaining. 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, collection agency fees, attorney fees and court fees.

I understand that if I am a self pay patient, that all payments are due at time of service.

I have read, or have had read to me, the above consent. By signing below I agree to the above and allow the doctor, affiliated with Center for Natural Health and Rehabilitation to perform such. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I 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.

_____ _____/____/_____

PATIENT SIGNATURE OR SIGNATURE OF GUARDIAN **DATE**

_____ _____

PRINT PATIENT NAME **PRINT GUARDIAN NAME**