

PATIENT CONSENT AUTHORIZATION
Buckeye Chiropractic Clinic, Inc.

CONSENT FOR TREATMENT: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedure. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

ASSIGNMENT OF BENEFITS: I hereby assign payment directly to the physician(s) accepting this assignment of medical benefits applicable and otherwise payable to me but not to exceed the physician's regular charges. I understand that I am financially responsible for charges not covered by this assignment or for any and all charges which the insurance carrier declines to pay. It is further agreed that any credit or balance resulting from payment of insurance or other sources may be applied to any other accounts owed to said physician by the insured or his/her family.

RELEASE OF INFORMATION: The physician(s) may disclose all or part of the patient's record to any person or corporation which is or may be liable under contract to the physician(s) or to the patient or to a family member or employer of the patient for all or part of the physician(s) charges, including but not limited to, insurance companies, worker's compensation, welfare funds, or the patient's employer.

H.M.O. DISCLAIMER: I certify that I am not presently enrolled in any Health Maintenance Organization (HMO) Subsequent rejection of a claim as a result of this admission, due to current enrollment in a H.M.O. plan will constitute responsibility for payment of claim on my part.

MEDICARE AND MEDICAID PATIENT CERTIFICATION – PATIENTS CERTIFICATION

AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act, is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim, I request that payment be made on my behalf. I assign the benefits payable for physician(s) serviced. I understand that I am responsible for my health insurance deductibles and coinsurance.

Verification of non-pregnancy

Date _____

Print Patient's Name

Witness

Patient's Signature