

Baker Chiropractic & Acupuncture Consent Agreement

Consent for Treatment

I understand that my outpatient registration, treatment or series of treatments by Baker Chiropractic & Acupuncture is necessary because of my condition. I voluntarily authorize and consent to the usual examination and treatments ordered by the Doctor and staff.

Consent for treatment of a Minor

I (We) being the parent, guardian, or custodians of _____, a minor, the age of _____, do hereby authorize, request and direct Dr. Baker to perform in his/her judgment and necessary examinations, x-rays and recommended treatment for the condition.

Request for Records

I hereby authorize Dr. Baker and Baker Chiropractic & Acupuncture to request any medical records, x-rays, and specialized testing results, including serum and tissue testing results for the purpose of giving a better diagnostic picture. I permit a copy of this authorization to be used in requesting my records from any and all health care facilities, Physician, and health care providers.

Payment & Insurance Release

I permit a copy of this authorization to be used in place of the original by Baker Chiropractic & Acupuncture. I authorize release to the Health Care Financing Administration and its agents any information needed to determine these benefits are payable.

I authorize any holder of medical information about me to be released to any of the above named health insurance or their contracted claims paying agents, and all information necessary to determine if these benefits are payable.

When I pay by check, I expressly authorize this provider, if my check is dishonored or returned for any reason, to debit my account for the amount of the check plus a processing fee of \$25.00 plus any applicable sales tax. The use of a check for payment is my acknowledgment and acceptance of this policy and its terms.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. However, I also understand and agree that all services rendered me are charged directly to me and services rendered me will be immediately due and payable. I further agree and understand that if the need arises, accounts delinquent by 90 days may be placed into legal collection agency. I understand and agree that I am responsible for all court cost, collection agency fee, filing fees and attorney fees that are incurred to collect my debt.

Date

Patient's Signature

Witnessed by:

Patient/Guardian's Signature-if applicable