PATIENT CONSENT AUTHORIZATION

CONSENT FOR TREATMENT: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. 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 that the insurance carrier declines to pay. It is further agreed that any credit or balance resulting from payment 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 a 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 carriers, welfare funds or the patient's employer.

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

VERIFICATION OF NON-PREGNANCY: I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.

MEDICARE AND MEDICAID PATIENT CERTIFICATION – PATIENT'S 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 Centers for Medicare and Medicaid Services or its agents, any information needed to determine these benefits or benefits payable for related services. I request that payment of authorized benefits be made on my behalf to the group/physician(s) accepting this assignment. I assign the benefits payable to physician(s) services. I understand that I am responsible for my health insurance deductibles and coinsurance.

PRIVACY NOTICE: I acknowledge that I have received a copy of Fairfield Family Chiropractic LLC's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal law.

X_____ **X**_____

Print Patient's Name Witness

X_____ _____

Patient's Signature Date

X_____

Other than patient, print name & relationship