PERINTON HILLS CHIROPRACTIC PC

585-223-2610

Authorization/ Consent

Patient's Name: _____

I authorize treatment of the above patient and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and members of my family shown by statements, promptly upon receipt, unless credit arrangements are agreed upon in writing. Charges shown by statements are agreed to be correct and reasonable unless protested within thirty days of the billing date. I agree that if my account is referred to an outside agent for collections, I am responsible for all the collections and/ or attorney fees.

It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection of claims. A copy of this assignment is as valid as the original.

Signature: _____ Date: _____
(Patient, Parent, Guardian)

Witness: _____