



## INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND FINANCIAL AGREEMENT

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 below, for whom I am legally responsible by the doctor or intern affiliated with Wellness Choice Center.

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interests.

**Financial Agreement:** I agree that in return for the services provided to me by the Wellness Choice Center I will pay my account at the time service is rendered or will make financial arrangements satisfactory to the Wellness Choice Center for payment. If an account is sent to collections, I agree to pay collection expenses. I understand and agree that if my account is delinquent, I may be charged a service fee. Any benefits on any type under any insurance policy insuring the patient or any other party liable to the patient is hereby assigned to the Wellness Choice Center. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of the bill.

Wellness Choice Center accepts the charge determination of the carrier as the full charge, and I am responsible only for the deductible, coinsurance, co-pays, and non-covered services. Coinsurance and deductibles are based upon the charge determination of the carrier and are due at the time of service.

I also understand that if I cancel or fail to show up for a scheduled appointment at Wellness Choice Center, I may be charged a cancellation fee which is at the discretion of Wellness Choice Center.

**Assignment of Benefits:** I agree that payments intended for the Wellness Choice Center in return for services provided to me which are covered by my insurance policy and are sent to the undersigned patient or authorized recipient on behalf of the patient will be repaid to the Wellness Choice Center.

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

\_\_\_\_\_  
Patient's Name (Please Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Signature (Or Guardian If Under 18)