

CONSENT FOR SERVICES

As a condition of your treatment by the office of Heights Atlas Orthogonal Chiropractic Clinic, P.A. financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the cost incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

Any Chiropractic services performed without previous financial arrangements or emergencies must be paid for at the time services are performed.

Patients who carry insurance that includes chiropractic cost understand that all chiropractic services furnished by Heights Atlas Orthogonal Chiropractic Clinic, P.A. are charged directly to the patient and that he or she is personally responsible for payment of all chiropractic services. This office will assist in answering any questions that will help the patient in filing a claim to their insurance company. Heights Atlas Orthogonal Chiropractic Clinic, P.A. will not render services on the assumption that our charges will be paid for by an insurance company.

In consideration for the professional services rendered to me, I agree to pay therefore the full amount for chiropractic services to Heights Atlas Orthogonal Chiropractic Clinic, P.A. or their assignee at the time of services are rendered.

I grant my permission to Heights Atlas Orthogonal Chiropractic Clinic, P.A. or their assignee to telephone me at home or at my work to discuss matters related to this form.

I give Heights Atlas Orthogonal Chiropractic Clinic, P.A. permission to release information to my insurance company if the insurance company or I make contact. I have read the above conditions of treatment and agree to their consent.

CONSENT TO TREATMENT

I authorize the chiropractors of Heights Atlas Orthogonal Chiropractic Clinic, P.A. to perform chiropractic adjustments, treatments and procedures of chiropractic. I further consent to X-rays examinations, laboratory procedures, consulting services, and diagnostic procedures rendered in conjunction with the adjustments, treatments and procedures.

PRINT PATIENT'S NAME

SIGNATURE OF PATIENT, PARENT OR
GUARDIAN

_____/_____/_____
DATE