 CONSENT, ASSIGNMENT, AND AGREEMENT

Before we will begin providing any health care you must read and sign this consent form stating that you understand and agree.

1. I certify that all the information given is true and correct to the best of my knowledge. I give my consent to Cartwright Chiropractic Inc. to render treatments to myself/my child as deemed necessary by the attending physician. I understand that I have the right to refuse services at any time, and will be informed of any changes in treatment prior to their performance. My written consent need only be obtained one time for all subsequent care given to me or my child in this office.
2. I understand that I am fully responsible for the payment of services rendered. I further understand that health and accident insurance policies are an arrangement between myself and the carrier, and that I may be required to pay some or all of the fees charged to my account. I hereby assign benefits to be paid directly to this provider by my third-party payer (i.e. insurance company, attorney, etc.). My signature below shows agreement that this is a non-rescindable agreement and failure to fulfill this obligation will be considered a breach of contract between myself and Cartwright Chiropractic Inc. I understand and agree to allow this chiropractic office to use their PHI for the purpose of treatment, payment, operations, and care.
3. I give my consent to Cartwright Chiropractic Inc. to perform x-rays as deemed necessary by the attending physician. I declare that, to the best of my knowledge, I am not pregnant/my child is not pregnant nor are there any known complicating limitations which would forbid taking x-rays. (Please cross out this paragraph if you are currently pregnant).
4. I agree to pay for services rendered which are denied by my insurance or are not covered by my insurance. I also agree to pay Cartwright Chiropractic in full if I am paid directly by my health insurance company, by an auto insurance company, or by my attorney. I understand that I am responsible for any and all pre-authorizations, prior authorizations and/or forms required by insurance for authorization or claim approval. I agree to pay a 12% interest on any outstanding balance on my account.
5. If the patient refuses to sign this form, the chiropractic physician has the right to refuse to give care.
6. If I am receiving treatment for an accident:
7. I understand that this is an express contract to pay for the services rendered by this Clinic. I agree to pay my account balance in full and/or direct its payment from My Claim proceeds regardless of whether any other person or entity attempts to or fails to fully reimburse me for it. If I dispute my account balance or treatment rendered, I agree that my remedy will be to resolve it with a separate action from My Claim.
8. I now assign, without any right to later revoke, proceeds from my claim equal to the fees incurred by me to this Clinic for all treatment and other services rendered by this Clinic. I am not assigning any legal cause of action in My Claim above, but only prospective proceeds. I also assign to the Clinic my right to enforce obligation of any insurance company to pay settlement proceeds directly to Cartwright Chiropractic.
9. I understand that it is my responsibility during treatment to remain aware of my cumulative account balance for services rendered.
10. I direct any insurance company, attorney, or other person who holds or later holds any proceeds from my claim to apply proceeds from my claim to my total account balance out of the total proceeds. I realize that by signing this form, I have agreed to give away proceeds from my claim to Cartwright Chiropractic equal to the full cost of all services rendered. If I receive any proceeds from my claim, I agree to immediately determine if this clinic has been paid in full. Unless the clinic confirms full payment in writing, I realize that any use by me of these proceeds is stealing money that is the property of Cartwright Chiropractic.
11. I understand that I remain responsible for any Clinic fees not paid out of My Claim.

I HAVE READ THIS DOCUMENT AND I FULLY UNDERSTAND IT.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Patient or Parent/Legal Guardian Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print or Type Patient Name