SALINA
CHIROPRACTIC

Patient Agreement

CONSENT TO TREATMENT: **I understand that medicine, surgery, and chiropractic are not exact sciences and that there is no guarantee that the outcome of my treatment will be what I want it to be. Doctors of Chiropractic are not internal medicine specialists, every patient should be mindful of his / her own symptoms and should secure other opinions if he / she has any concern as to the nature of his / her total condition. Knowing and agreeing to this , I request to be a patient with Salina Chiropractic. I consent to necessary testing and treatment while I am a patient.**

RECORDS: **All records including x-rays remain the personal property of Salina Chiropractic. I understand that my medical records are confidential. I hereby give my voluntary consent to Salina Chiropractic to release to, or allow review by, my insurance companies, or other third party payers or their designated representatives, such portions of my medical records as are necessary to obtain reimbursement or to determine appropriateness of treatment. The consent shall be valid for one year from the date of the last service provided. I release Salina Chiropractic from all liability that may arise from the release of information requested.**

FEE FOR NO SHOW: **I understand that if I must miss a scheduled appointment I am required to call PRIOR to my appointment to reschedule or cancel. I understand and agree that there is a $40.00 fee for all "no shows" and that this fee is my personal responsibility and is not billable to insurance.**

ASSIGNMENT OF BENEFITS: **I understand it is my responsibility to satisfy any conditions of my insurance company. I assign benefits otherwise payable to me to be paid directly to Salina Chiropractic for my care.**

PROMISE TO PAY: **The undersigned agrees whether he / she signs as the patient or the patient's representative, that in consideration of the services to be rendered to the patient, the undersigned hereby individually obligates him / her self to pay Salina Chiropractic in accordance with their regular rates and terms. If insurance coverage is insufficient, denied altogether for any reason, or is otherwise unavailable, the undersigned agrees to pay all charges not covered. Further, should the account be referred to an attorney or collection agent for collection, the undersigned agrees to pay reasonable attorney's fees and other costs of collection as allowed by law. Undersigned further agrees and understands that Salina Chiropractic accepts no liability for failure to meet any pre / post certification procedures which may be required of the patient or the patient's representative by insurance companies and agree that any such procedures will b properly executed in a timely fashion. I understand and agree that overdue account balances are subject to interest at the rate of 1.5% per month (18% per annum) or a $5.00 monthly rebilling charge, whichever is more, until the account is paid in full.**

I CERTIFY THAT I HAVE BEEN GIVEN THE OPPORTUNITY TO READ OR HAVE HAD THE ABOVE INFORMATION EXPLAINED, THAT I FULLY UNDERSTAND ALL SECTIONS, THAT I HAVE RECEIVED A COPY, AND I AM THE PATIENT OR DULY AUTHORIZED BY THE PATIENT AS THE PATIENT'S GENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPT IT'S TERMS.

_____	_____	_____
Date	**Patient or Authorized Signature**	**Relationship to Patient**
_____	_____	_____
Date	**Witness**	**For Salina Chiropractic**