Paul M. Bizzaro, O.C. 81 South Main Street Yardley, PA 19067

Telephone: 215.493.6589

Fax: 215.493.1022

Informed Consent:

I hereby request and consent to the performance of chiropractic procedures, Including various modes of physical therapy and diagnostic x-rays on me or on the patient named below for whom I am legally responsible for by the Doctor of Chiropractic named above and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working for, or associated with, or serving as back-up for the doctor of chiropractic named above, including those working at the clinic or office listed above, or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office clinic personnel regarding the nature and purpose of chiropractic adjustments and procedures.

I understand and am informed that as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, disc locations, and sprains. I do expect the doctor to exercise judgment during the course of the procedure which the doctor feels, at the time, based upon the facts known are administered in my best interest.

I have read, or have had read to me, the above consent. I have also had the opportunity to discuss or ask questions related to its content, and by signing below, I agree to the above named procedures and for any conditions in the future for which I seek treatment.

Patient Name (Print} \_ Signature Date \_

Our policy requires payment in full for all services rendered at the time of the visit unless other arrangements are made with in the office manager. How will you be paying for today's visit?

 Cash \_\_

Check \_\_

Credit Card

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release information to process insurance claims. I understand the above information and guarantee this form was completed correctly and to the best of my knowledge and understand that it is my responsibility to inform this office of any changes in my medical status.

Signature \_ Date \_\_\_

### **PATIENT LIABILITY AGREEMENT**

I understand that I am financially responsible for all bills of Paul Bizzaro. D. C. In the event that my account is not paid, l shall be liable for any and all costs of collection, including but not limited to an additional 33.33 % fee if my account is forwarded to WJG Collection Agency, Inc. for collection. In addition, I further understand that I will also be responsible for paying any reasonable attorney's fees plus court costs. Further, there will be a 2 % annual finance charge on all accounts past due at least 30 days.

By signing below, I hereby indicate that 1) I have read this contract. 2) I understand the

terms of this contract and 3) I agree to terms of this contract

###### Date: \_

Patient Signature