CORFMAN CHIROPRACTIC & REHAB

Today's Date: ___/ ___/ ___

CONSENT FOR TREATMENT:

I, ____ (PRINT), do hereby authorize Dr. Charles Corfman and whomever he may designate as his assistants to perform diagnostic tests, including but not limited to radiographs, physical examination and administer treatment as directed, indicated or deemed necessary. This includes emergency actions that may need to be performed should I be physically incapacitated. Complications to chiropractic care may include rib fracture and stroke, however, specific tests designed to minimize these risks are employed and do minimize these outcomes. **I ALSO CERTIFY THAT IN NO WAY HAVE ANY GUARANTEE OR ASSURANCES BEEN MADE AS TO THE RESULTS THAT MAY BE OBTAINED.** I understand and agree that health and medical insurance policies are an arrangement between an insurance carrier and myself (patient). Furthermore, I understand and agree that this office and contracted representatives may prepare any necessary reports and forms to assist me in making collection from the insurance company, and that any amount authorized to be paid and sent directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. However, I clearly understand and agree that I have sought treatment, received treatment, and am directly responsible for the bills that accumulate from this treatment.

Patient/Guardian:
Name Printed: ________________________________
Name Signed: ________________________________ Date: ____________
Witness:
Name Signed: ________________________________ Date: ____________

CONSENT FOR TREATMENT OF A MINOR:

I hereby authorize Dr. Charles Corfman and whomever he may designate as an associate or contractor of this clinic to perform diagnostic tests, radiographic studies, physical evaluations, and to administer treatment as they deem necessary to____, a minor child under my guardianship. I also accept all terms and conditions named herein with regards to payment of the account and lien arrangements and am responsible for the execution of these agreements on this minors behalf.

Patient/Guardian:
Name Printed: ________________________________
Name Signed: ________________________________ Date: ____________
Witness:
Name Printed: ________________________________
Name Signed: ________________________________ Date: ____________

ASSIGNMENT OF BENEFITS:

I hereby authorize the following insurance companies or liable direct pay parties:

1. ____
2. ____
3. ____
4. ____

To pay by check or credit card through either mailing the check payable to either Dr. Charles Corfman at 2530 Florence Blvd. Suite C, Florence, AL 35630. This covers the expense benefits allowable and otherwise payable to me under my current policy, as payment towards the total charges for professional services rendered I have agreed to pay, in a current manner, any balance of said applicable charges. I further state that this office is given a **limited power of attorney to endorse/sign my name on any and all drafts directed for the payment of my bill.**

Patient:
Name Printed: ________________________________
Name signed: ________________________________ Date: ____________

Witness:
Name Printed: ________________________________
Name Signed: ________________________________ Date: ____________