

**STARMAN CHIROPRACTIC CENTER**

**Patient Consent Authorization**

CONSENT FOR TREATMENT: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

ASSIGNMENT OF BENEFITS: I hereby assign payment directly to the physician(s) accepting this assignment of medical benefits applicable and otherwise payable to me but not to exceed the physician's regular charges. I understand that I am financially responsible for charges not covered by this assignment or for any and all charges that the insurance carrier declines to pay. It is further agreed that my credit or balance resulting from payment of insurance or other sources may be applied to any other accounts owed to said physician by the insured or his/her family.

RELEASE OF INFORMATION: The physician(s) may disclose all or part of the patient's record to any person or corporation which is or may be liable under a contract to the physician(s) or to the patient or to a family member or employer of the patient for all part or part of the physician(s) charges, including but not limited to, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

MEDICARE AND MEDICAID PATIENT CERTIFICATION - PATIENTS  
CERTIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT  
REQUEST: I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act, is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its Intermediary carriers, any information needed for this or related Medicare or Medicaid claims. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services. I understand that I am responsible for my health insurance deductibles and coinsurance.

MISSED APPOINTMENT POLICY: It is our office policy that we do not double-book appointment times for our patients. To respect our patients' time and minimize waiting time for those in our office we ask that you notify us within 24 hours if you need to change or cancel your appointment. There is a \$25 fee for last minute cancellations or no-shows.

X \_\_\_\_\_  
Print Patient's Name

X \_\_\_\_\_  
Patient's Signature

**Women: Verification of non-pregnancy**  
By my signature on this form I, do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.

X \_\_\_\_\_  
Other than patient, print name & relationship

X \_\_\_\_\_  
Witness