MEDICAL CONSENT FORM

1.) **MEDICAL CONSENT:** The patient is under the control of his Chiropractic Physician and the undersigned consents to any x-ray, examination, laboratory procedures, diagnostic service, or other services rendered the patient under the general and specific instructions of Dr. Montgomery.

2.) **CONSENT TREATMENT:** I hereby agree to the performance of treatment services as in the opinion of Dr. Montgomery are deemed necessary.

3.) **RELEASE OF INFORMATION:** The facility and Dr. Montgomery may disclose all or any part of the patient's record to any person or corporation which is or may be liable under a contract to Dr. Montgomery or to the patient or to a family member or employer of the patient for all or part of the medical charges, including, but not limited to medical service companies, workers' compensation carriers, welfare funds or the patient's employer.

4.) **ASSIGNMENT OF BENEFITS:** In the event the undersigned in entitled to medical benefits of any type whatsoever arising out of any policy of insurance insuring patient or any other party liable to patient said benefits are hereby assigned to Dr. Montgomery for application on patient's bill, and it is agreed that Dr. Montgomery may receipt for any such payment and such payment shall discharge the said insurance company of any and all obligations under the policy to the extent of such payment, the undersigned and or patient being responsible for charges not covered by this assignment.

5.) **FINANCIAL AGREEMENT:** The undersigned agrees whether he signs as agent or as patient that in consideration of the services to be rendered to the patient, the hereby individual obligates himself to pay the account in accordance with the regular rates and terms of the facility. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection fees and collection expenses. A 0.1% service charge will be assessed on all account balances past 30 days. ***Any dispute will be resolved in our Jurisdiction.***

The undersigned certifies that he has read the foregoing, is the patient, or is duly authorized by the patient as the patient's general agent to execute the above and accept the terms.

_____ _____

Patient's Signature Date

_____ _____

Guardian's Signature Date

IF PATIENT IS A MINOR, PARENT OR GUARDIAN MUST AUTHORIZE TREATMENT TO BE ADMINISTERED TO PATIENT.