

Knoxville Chiropractic Clinic, P.C. Dr. Larry Formanek
115 E. Main Street
Knoxville, IA 50138
(641)842-3007

Patient

First Name _____ **M.I.** _____ **Last** _____ **Chart #** _____

Financial Agreement: I understand that there is no guarantee of payment from any insurance company or other payer. I agree to pay all charges for the services provided by Knoxville Chiropractic Clinic, P.C. which are not paid by my health insurance or other payer. I clearly understand I am personally responsible for payment and that all charges are due and payable when I receive the bill, unless other arrangements are made in advance. I also understand that I may terminate my care and treatment, however upon doing so any fees for professional services rendered to me will be immediately due and payable.

Assignment for Direct Payment: I authorize the payment of any insurance (including healthcare insurance and/or auto insurance) benefits for health care services or goods be made directly to Knoxville Chiropractic Clinic, P.C., 115 E. Main Street, Knoxville, IA 50138

Authorization for Release of Information: Knoxville Chiropractic Clinic, P.C. may release information from my chiropractic health records to any health care provider involved in my care and treatment. Knoxville Chiropractic Clinic, P.C. may also release information from my chiropractic health records to any person or organization liable for all or part of my charges, such as my insurance carrier, any third-party payer, the Medicare or Medicaid programs, and my employer's workers' compensation carrier. I acknowledge that upon disclosure of my chiropractic health record information to an insurance company or other payer pursuant to this authorization, Knoxville Chiropractic Clinic, P.C. is no longer responsible for the confidentiality of any information known or possessed by the payer.

Informed Consent for Health Services: I hereby request and consent to the performance of chiropractic treatment including chiropractic adjustments and other chiropractic procedures, including various modes of physical and physiotherapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by Dr. Larry M. Formanek, D.C. of the Knoxville Chiropractic Clinic, P.C. and whomever he may designate as his assistants to administer treatment.

I have had an opportunity to discuss with the doctor of chiropractic named above or with other office and clinic personnel the nature and purpose of chiropractic adjustments and other procedures, I understand that results are not guaranteed. 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, stroke, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon facts that are known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present conditions and any future condition(s) for which I seek treatment with Dr. Larry Formanek, D.C. and Knoxville Chiropractic Clinic, P.C.

Signature of Patient _____ **Date:** _____
or Parent/Guardian of Minor Patient

Consent to Treatment of Minor Child: I hereby authorize Dr. Larry M. Formanek and whomever he may designate as assistants to administer chiropractic care including x-rays described above for the treatment of my minor child or the minor for which I am legally responsible.

Birth date of Child: ____ / ____ / ____

Signature of Parent/Guardian: _____ **Date:** _____

Witness: _____ **Date:** _____