Sherri R. Collett, D.C.
124 Chenoweth Creek Rd.
Elkins, WV 26241
304-636-9610

PATIENT CONSENT

CONSENT FOR TREATMENT

I voluntarily consent to the rendering of care, including examination, treatment and performing of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it's responsibility of the staff to carry out the instructions of such physician.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

MEDICARE AND MEDICAID CONSENT TO RELEASE INFORMATION

I certify the information given by me in applying for payment under the Title XVIII and or/ Title XI of the Social Security Act is correct. I authorize any holder of medical information about me , to release to the Social Security Administration or it's intermediary carriers, any information needed for this related Medicare or Medicaid claim.

FINANCIAL AGREEMENT/SIGNATURE ON FILE

I am signing a financial agreement stating that I am fully responsible for any payments due to Collett Family Chiropractic, INC. that are denied by my /any insurance plans or third party payers. In the event any third party payer does not pay for services provided to me and billed by Collett Family Chiropractic , INC in a timely manner, I will pay them in full. If I do not make mutually satisfactory written arrangements for a payment plan (and continue making regular payments until paid in full) I understand all past due amounts will be considered for collections.

Furthermore, I understand that Collett Family Chiropractic, INC will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any payment of medical benefits I authorize to be paid directly to Collett Family Chiropractic will be credited to my account on receipt. I authorize the release to my insurance company any medical information necessary to process my claim.

_____ _____

Signature Patient or Authorized User Date