



**Consent for Examination and Treatment**

I hereby consent to evaluation and treatment by Back 2 Life Health Center and/or its clinical staff for either my dependent or myself. I understand there are certain risks associated with any examination and treatment and those risks have been presented and explained to me.

**Office Financial Policy**

All payments are expected at the time of service unless other arrangements have been made in advance. My personal balance may not exceed \$100 at any time or care maybe be terminated. Unpaid personal balances over 30 days are subject to a \$5 minimum or 1.5% interest per month. I will be charged \$25.00 if I do not show or do not cancel my scheduled appointment within 24 hours.

*Insurance* – I authorize payment directly to Back 2 Life Health Center for services rendered. This is a direct assignment of my rights under this policy. I agree to immediately forward to Back 2 Life Health Center any reimbursements which I may receive, which are issued for the purpose of payment for my treatment. I understand that Back 2 Life Health Center cannot guarantee payment, coverage or benefits from my insurance company. I agree to make every effort to remain informed about the extent and/or limitations of my insurance coverage and will adhere to any requirements by my insurance company in order to facilitate payment of my claims. I acknowledge responsibility for any and all account balances, legal fees, and all interest charges and other expenses incurred in collecting your account. I hereby accept responsibility for treatment costs incurred that are not covered by my insurance.

**Release of Medical Information**

I give permission to Back 2 Life Health Center to release information, verbal and written, contained in my medical record and other related information to my insurance company, attorney, employer, school, related healthcare provider, assignee and/or beneficiaries and all other elated persons as it relates to my treatment. I authorize Back 2 Life Health Center to obtain medical records and/or professional information from my physician or other medical professional, attorney and insurance company as it relates to my treatment and claim.

I have read all of the above information. I understand my obligations as outlined by this release.

Print Name \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_