Balance 4 Life Chiropractic

"Chiropractic, Nutrition, Fitness, and You"

Consent for Treatment & One-Time Authorization

The following information is to be completed by the patient, or the patient's legally authorized representative:

I Consent to chiropractic treatment recommended by Dr. Kenneth D'Souza D.C. for myself or for the patient for whom I am the parent or legally authorized representative. I understand that Balance 4 Life Chiropractic will share patient health information according to federal and state law for treatments and payments.

I understand that as the patient I am responsible for all charges incurred, regardless of my health insurance status. I understand that it is my responsibility to obtain and confirm my health insurance benefits with my health insurance company. I agree to pay for services as I incur the charges. I authorize my health insurance company(s) to pay Balance 4 Life Chiropractic for all approved services rendered to me.

Print Patient Name: ___________________________________

Signature of Patient: __________________________________ Date: ____________

Signature of Legally Authorized Representative: _____________________________________

Relationship to Patient: ________________________________ Date: _____________

For Medicare Beneficiaries, only:

I request that payment of authorized Medicare and Medigap benefits be made on my behalf for any services furnished to me by or in Balance 4 Life Chiropractic, including provider services. I authorize any holder of medical information about me to release to the Center of Medicare & Medicaid Services (CMS), its agents, and my current Medigap Insurer, any information needed to determine these benefits payable for related services.

Signature: _______________________________________ Date: ____________

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