

# 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 and soft tissue 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: \_\_\_\_\_

Print Legal Representative Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Legally Authorized Representative: \_\_\_\_\_

### **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: \_\_\_\_\_