CONSENT TO SERVICES

1. I ______________________________ authorize performance upon my person the following procedure(s):

_______Manipulation _______Examination
_______Physical Medicine _______Other______________________________

2. In addition, I understand that other examination and treatment procedures may be necessary throughout the course of my admission and I understand that I will be so informed of the intent to perform and risks and benefits of the proposed procedures.
3. The nature and purpose of these procedures, possible alternatives, and the risks involved, the possible consequences and the possibility of complications have been sufficiently explained to me by clinic physicians and/or their designees.
4. I understand that there are charges for these procedures and that they will be explained to me by the finance department upon my request.

Signature:____ Date:__________

Do you have health insurance? ☐Yes ☐ No

Name of Company____ Policy#_______________

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself.

I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorneys who represent me due to my condition, and to complete any usual and customary reports and forms to assist in collecting from my insurance company, attorneys, or payers.

ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned claimant, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/ or dependents. I further expressly agree and acknowledge that my signature on this documents authorizes **Performance Wellness Centers** to submit claims for benefits, for services rendered or for services to be rendered without obtaining a signature on each and every claim to be submitted for me and/ or dependents, and that I will be bound by this signature as though the undersigned has personally signed the particular claim.

I hereby authorize **My Insurance Company**:_____________________________ to pay and hereby assign directly to **Performance Wellness Centers** all benefits, if any, otherwise payable to me for services as described on the detached forms, and I also agree to pay co-payments and/or deductibles on a weekly basis.

I understand that I am financially responsible for all charges incurred and that any insurance benefits, when received by and paid to **Performance Wellness Centers** will be credited to my account in accordance with the above assignment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I have read, understood, and agree to the foregoing. The information that I have provided is true and complete to the best of my knowledge.

I further acknowledge that verification of benefits is not a guarantee of payment from my insurance company.

Signature:____ Date____________________