Bowman Chiropractic

3868 East Robinson Road
Amherst, NY 14228
(716) 564-2225

7312 Niagara Falls Blvd
Niagara Falls, NY 14304
(716) 236-7176

Fax 888-484-2163
bowmanchiro@gmail.com

Patient Name: _____ Date: _____

Authorization for Release of Records:

To _____, I hereby authorize you to release to Bowman Chiropractic any information including the diagnosis and records of any treatment rendered to me during my period of treatment.

Signature: _____ Date: _____

Authorization for Assignment of Benefits:

I authorize payment of any medical benefits to be paid directly to Bowman Chiropractic for any services rendered to me.

Signature: _____ Date: _____

Notice of Patient Privacy:

By signing below I certify that I have received and reviewed this notice and all of my questions have been answered to my satisfaction in a language I can understand.

Signature: _____ Date: _____

Consent to Treat and/or Consultation:

I understand and am informed that as in all health care in the practice of chiropractic there are some risks to treatment, including but not limited to, muscle strains and sprains, fractures, dislocations, disc injuries and stroke. I do not expect the doctor to be able to anticipate or explain all risks and complications. I wish to rely on the doctor to exercise judgement during the course of the treatments which they feel at the time, based upon the facts then known, is in my best interest. I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about its content. By signing below, I consent to treatment.

Signature: _____ Date: _____

Acknowledgement of Financial Liability:

I understand that I may be financially responsible for any charges incurred at this office, including co-payments, deductibles, all collection and/or legal fees on any unpaid account referred for collection and charges denied or not covered by my insurance company. I realized my care may be subject to pre-authorization by the insurance company, and I accept any responsibility for charges, which may not be approved. The insurance company will review any and all documentation submitted by Bowman Chiropractic for review for medical necessity and base their approval/denial upon this documentation. Insurance policy limitations are per individual insurance policy plans, as are co-payments, co-insurance, deductibles, referrals, etc. I understand that this office agrees to notify me if a service is not covered and will make me aware of the number of visits allowed. Initial visits may be denied and this may be beyond the office's ability to notify the patient prior to rendering acute care, while waiting for the insurance coverage approval. These charges will be the patient's responsibility if denied by the insurance company. This office may seek payment from you for any series your health insurance plan determines to be not medically necessary. I have read and understand my obligations for payment for care in the absence of insurance coverage. Our office policy is collection of any and all co-payments upfront before services are rendered.

Signature: _____ Date: _____