Name: _____

Consent to Treat a Minor:

I hereby authorize Goodman Chiropractic, LLC and whomever they may designate as their assistants to administer diagnostic and chiropractic care as they deem necessary for _____, for whom I am the parent or legal guardian.

Signature of Parent/Guardian: _____ Date: _____

Billing Information:

IN ORDER TO CONTROL THE COST OF BILLING, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT:

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid to this office will be credited to my account upon receipt. I permit this office to endorse co-insured remittances for the conveyance of credit to my account. However I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. It is my understanding that my credit may be checked if Goodman Chiropractic extends credit to me and I also hereby authorize that the doctor at Goodman Chiropractic and whomever he may designate as his assistants to administer treatment as they deem necessary and I also authorize the release of any information acquired in the course of my examination or treatment. In the event that full payment for charges incurred in my medical care is not made, I agree to pay all costs of collection, including 33 1/3% up to 50% Collection Agency Commission, reasonable attorney's fees and interest at the rate of 18% per annum. I also agree to submit myself to the jurisdiction of the courts of Utah County, UT. I certify that the above information is true and correct.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

Signature: _____ Date: _____

Insurance Agreement:

Goodman Chiropractic has elected to be a contracted provider for most insurance companies. We do this to help patients make better use of their insurance benefits. Also, we have offered to verify your chiropractic coverage on the first visit. This should only be used as a confirmation of your own investigation into your insurance benefits. Because we often receive incorrect information from insurances companies, we do not guarantee that our information is correct. We can only bill the insurance according to what has been told to us.

Some insurance's require pre-approval. We will do our best to get the approvals from them, but because each insurance has different qualifications, we cannot guarantee all of your visits will be pre-approved. In which case you will be billed the contracted rates for those visits.

Goodman Chiropractic offers a cash incentive outside of insurance coverage. Generally this amount is less than the amount billed to the insurances because there is considerably less time and work needed to receive reimbursement. If you choose this plan, we will not bill your insurance. We are happy to give you a receipt that you may turn into your insurance company for reimbursement.

Thank you for choosing our office for your chiropractic needs. We are confident you will be happy with your care.

Signature: _____ Date: _____