PREFERRED CHOICE CHIROPRACTIC

ADMISSION CONSENT AND AUTHORIZATION

1. Consent for Treatment

I hereby agree to the performance of such procedures and treatments that in the opinion of my treating chiropractic physician deems necessary. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interests.

2. Consent to Release Medical Records to Other Providers

I consent to the release of information about my medical condition to any health care provider currently involved in my treatment.

3. Acknowledgement of Receipt of Notice of Privacy Practices

Preferred Choice Chiropractic reserves the right to modify the privacy practices outlined in the notice.

X _____My initials indicate I have received a copy of the Notice of Privacy Practices for Preferred Choice Chiropractic.

4. Assignment of Insurance Benefits and Guarantee of Account

I request that payment of authorized health insurance, Medicare, and /or Medicaid benefits be made on my behalf to Preferred Choice Chiropractic, or to me in the case of non-assigned Medicare claims for any services furnished me by that clinic. I authorize payment directly to Preferred Choice Chiropractic of insurance, Medicare and/or Medicaid benefits, or other funds the patient or I, the undersigned, are entitled to receive from other sources for payment of services provided to me. I authorize Preferred Choice Chiropractic to release all health information about me to Medicare, Medicaid, third-party carriers, health service plan corporations, or health maintenance organizations listed on the Admission Record, and/or third party administrators, to determine payment of my Preferred Choice Chiropractic bill, payment of claims, fraud investigation, and/or quality of care review studies.

For services provided by Preferred Choice Chiropractic to me, the undersigned personally guarantee payment of the bill to Preferred Choice Chiropractic, P.A. incurred as a result of this health care service. This includes services, which for any reason are not paid by insurance, government programs, or other third-party sources. I shall, within thirty (30) days from the date of each billing statement, pay Preferred Choice Chiropractic the total balance thereon or the minimum periodic payment. The minimum periodic payment required is the greater of $25 or fifty percent (50%) of the entire unpaid balance of the account. If there is a failure to pay any minimum periodic payment when due, Preferred Choice Chiropractic may declare the entire balance due and payable and/or terminate any further extension of credit.

I will pay no Finance Charge on the new balance shown on the monthly statement if such new balance (less any credit issued) is paid in full within thirty (30) days after the date of the monthly statement. I agree to pay a Finance Charge at a rate of twelve percent (12%) per year on the balance of the account at the end of the monthly billing cycle, or a minimum Finance Charge of three dollars ($3.00) per month. Patients may, at any time, pay the full amount.

I agree to guarantee payment to Preferred Choice Chiropractic for alls costs incurred by Creditor in collecting payment, including but not limited to legal costs such as attorney fees, costs and fees, and service fees. I also understand that 12% interest per year may be added if the account balance goes to a collection agency.

I release such information about me and services rendered to me as is reasonably necessary to accomplish the collection of Preferred Choice Chiropractic's bill as a result of this health care service.

This consent and authorization is to remain in effect until I choose to revoke it in writing. I have also had an opportunity to ask questions about the content of this form, and by signing below I agree to the above terms.

X _____ _____

(Patient, Legal Representative, or Guarantor signature - if underage or patient unable to sign) (Date Signed)

_____ _____

(Patient's Personal Social Security Number) (Patient date of Birth)

_____ _____

Name of Patient (Print or Type) Relationship of Patient Representative to Patient