CONSENT TO TREAT

BECHTOL CHIROPRACTIC & ENDERMOLOGIE CENTER

DR. NIKKI L. BECHTOL, D.C.

PATIENT NAME (PRINT): _____

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed above.

I have had an opportunity to discuss with the doctor of chiropractic names below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

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 an explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I understand that as of January 1, 2015, Dr. Bechtol is no longer accepting any insurance of any kind. Payment, in full, is due at the time of services are rendered. Dr. Bechtol's obligation to her patients, is to continue to keep healthcare affordable and will remain with fees considered reasonable and customary for this area.

I have read, or have had read to me, the above consent. I have also had an opportunity to as questions about its content, and by signing below I agree to the above-names procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature_____ Date _____

Witness Signature_____ Date _____

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

Patient Name (please print) Date

_____

Parent, Guardian or Patient's legal Representative

_____

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationships of people to whom you authorize the Practice to release PHI.

_____ _____

_____ _____

BECHTOL CHIROPRACTIC & WELLNESS CENTER, INC
OFFICE OF DR. NIKKI L. BECHTOL

Cash Practice Notification

I, _____, fully understand that Bechtol Chiropractic and Wellness
Print Name
Center is a "Cash practice" and therefore will not bill my insurance company. I am aware that Bechtol Chiropractic and Wellness Center is not equipped to provide me with a "Insurance Friendly" receipt and therefore I will not be reimbursed by my insurance company at any time for services rendered.

I am aware that if Medicare is my primary insurance, I must be referred to a chiropractor that accepts Medicare, and participates in the Medicare program. By signing I understand that Dr. Nikki L. Bechtol is NOT a participate in any/all insurance plans.

WE BELIEVE IN GOOD OLE' FASHION HEALTH CARE. TREAT THE PATIENT AS A WHOLE, WITHOUT THRID PARTY INTERRUPTION. WE ARE HERE FOR YOU...NOT THEM!
THANK YOU FOR YOUR UNDERSTANDING. IF, AT ANYTIME FINANCES STAND IN THE WAY OF TREATMENT, PLEASE LET US KNOW. WE ARE FAMILY!

X _____ X _____ _____
Print Signature Date