Jones Chiropractic & Physical Therapy, LTD.

719& 721 S. Washington, Bunker Hill, IL 62014
Phone: (618) 585-3522 * Fax: (618) 585-3523

I, the patient, understand that **Jones Chiropractic & Physical Therapy, LTD.,** (now referred to as the "*clinic*") is the corporate entity of Bunker Hill Chiropractic and Bunker Hill Physical Therapy of which both keep separate patient and billing records. If this patient is treating at both offices, you may receive separate bills, liens, and claims for the same dates of service.

Authorization to Release Information

I am authorizing the *clinic* to release any information the *clinic* feels appropriate concerning my condition to any insurance company, attorney, or adjuster in order to receive reimbursement on any charges incurred by me as a result of services rendered by the *clinic* professionally.

Authorization to Pay Directly to the Clinic

I authorize direct payment to the *clinic* of any sum that I owe the *clinic* now or in the future from any insurance company that is obligated to reimburse me for charges incurred in the *clinic* in part, of full / or my attorney out of the proceeds out of my settlement. A photocopy of this form is acceptable for payment.

Assignment of Cause of Action

I hereby assign and give the *clinic* the right to take action against any insurance company that is obligated by contract to make payment. I authorize the *clinic* to take action in either my name or the *clinic's* name to resolve this claim. I fully understand that I am directly and fully responsible to the *clinic* for all bills submitted for services rendered to me, and that this agreement is made solely for the *clinic's* additional protection and in consideration of the *clinic* awaiting payment. And I further understand that such payment by me is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fees. I, the undersigned, expressly state that in the event that I fail to make payment to this *clinic* for any and all costs incurred as a result of the care and services rendered within a reasonable period of time, that I agree to pay the cost of collection, including reasonable attorney's fee as provided by law.

Informed Consent for Clinic Care

A patient, in coming to the *clinic,* gives the *clinic* permission and authority to care for the patient in accordance with the *clinic* testing, treatment, and analysis. The treatment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, an underlying physical defect, deformity or pathology may render the patient susceptible to injury. The *clinic* will not give adjustments or treatment if the provider is aware that such care may be contra-indicated. Again it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the providers of the *clinic*. That patient should look to the correct specialist for the proper diagnostic and clinical procedures. The *clinic* provides a specialized, non-duplicating health service. The providers of the *clinic* are licensed in a special practice and are available to work with other types of providers in your health care regime.

_____ _____

Signature of Legal Representative
(e.g. Attorney-In-Fact, Guardian, Parent if Minor)

Relationship

Patients Signature:_____ Dated: _____

Witness: _____