HANSEN CHIROPRACTIC CENTER

KEVIN M. HANSEN D.C, C.C.S.P.
3316 INDIANOLA AVENUE
DES MOINES, IOWA 50315
(515) 288-1302

WELCOME TO OUR OFFICE

TREATMENT PERMISSION: *I understand that if I am accepted as a patient and if I agree to be treated, that I give permission to the doctor to administer treatment and perform such general procedures as he deems necessary in the diagnosis and treatment of my condition. Furthermore, any risks regarding treatment will be explained to me upon my request.*

PAYMENT RESPONSIBILITIES: *I understand that I am personally responsible for all charges whether or not paid by any Third party. I agree that all charges are payable, collectible and prosecutable in Polk County. All portions of any bill sent me by Hansen Chiropractic Center shall be assumed valid unless disputed in writing within thirty days of receiving the bill.*

ASSIGNMENT OF RIGHT TO PAYMENT/LIEN AGAINST BENEFITS: *I authorize Hansen Chiropractic Center to file by claim. I assign to them my right to receive any and all payments or recoveries from any insurance company, attorney or third party for professional services rendered by Hansen Chiropractic Center. I convey a lien against any funds and authorize and direct any third party to withhold sums from any benefits, judgements, verdict, settlements, or recoveries, and to adequately protect and to make payment for these services directly to Hansen Chiropractic Center pursuant to this assignment and lien.*

ASSIGNMENT OF CAUSE OF ACTION: *In the event that any insurance company or other third party that may be obligated to make payment to me or to Hansen Chiropractic Center for the charges made for services, refuses to make such payment upon demand, I hereby assign, transfer and convey to Hansen Chiropractic Center the cause of action that might exist in my favor against any such company or person. I authorize Hansen Chiropractic Center to prosecute said action either in their name or my name to collect fees due for care rendered at Hansen Chiropractic Center and legal expenses and to resolve said claims as they see fit.*

AUTHORIZATION TO PROCESS DRAFTS: *I agree that Hansen Chiropractic Center shall be appointed as my agent to endorse drafts or sign my name on any checks for payment of my bill for chiropractic services rendered.*

LIMITIED RELEASE OF MEDICAL INFORMATION: *I authorize Hansen Chiropractic Center to make inquiries and to release any pertinent information to any insurance company, adjuster, medical facility, doctor or attorney to facilitate collection under these assignments.*

Our goal is to relieve your pain as quickly as possible, and then help you to reach pre-accident status. If you have any questions with regard to your health care or any of our policies, please let us know. We welcome your referrals and look forward to a doctor-patient relationship that works for our mutual benefit.

SIGNATURE____ **DATE**________________