DR. RODNEY K. SIMMER

Chiropractic Physician

3012 18th Avenue Rock Island, IL 61201
Office: 309-786-4131 Fax: 309-786-0797

AUTHORIZATION FOR CHIROPRACTIC CARE

I have been informed of the nature and purpose of Chiropractic care, the possible consequences of the care, and the risks of the care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained including the risk consequences and the probable effectiveness of each. I have been advised of the possible consequences if no care is provided. I acknowledge that no gaurantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH, I UNDERSTAND THE INFORMATION PROVIDED. THE INFORMATION HAS BEEN EXPLAINED TO ME AND ALL QUESTIONS, WHICH I HAVE ASKED, HAVE BEEN ANSWERED TO MY SATISFACTION.

HAVING THE KNOWLEDGE, I KNOWINGLY AUTHORIZE DR. SIMMER TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

____
PATIENT'S SIGNATURE DATE

____
NAME OF PATIENT – IF MINOR – & AGE

____
SIGNATURE OF AUTHORIZED PERSON FOR MINOR RELATIONSHIP TO MINOR

FINANCIAL RESPONSIBILITY STATEMENT

I understand and agree that insurance policies are an arrangement between an insurance carrier and myself. Futhermore, I understand that the Doctor's 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 directly to the Doctor's Office will be creditied to my account upon receipt. However, I clearly understand and agree that all series rendered me are chared directly to me and that I am personally responsible for payments. I also understand that if I suspend or terminate my care and treatment, against Doctor's recommendation, my account balance will be immediately due and payable. All past due accounts are subject to a finance charge of 1.5% per month or maximum rate allowed by law. The undersgined, responsible party, agrees to be personally responsible for all charges. If at any time, or for any reason, the undersigned is unable to pay for services when due, the undersigned agrees to pay and authorizes Dr. Rodney K Simmer DC to bill their account finances charges as described above. In the event it becomes necessary for Rodney K Simmer, DC to incur collection costs or institute suit to collect any amount due under this agreement. The undersigned also agrees to pay collection fees and expenses, including reasonable attorneys' fees and court cost plus all legal fees if incurrured for collection and submits to jurisdiction and venue in Rock Island County. I hereby certify that I have read and agree to the above terms.

Patient Signature____Date_______________SS#__________________________

Other Responsible Party__________________________________Date_______________SS#__________________________

Information taken by ____________________________________Date_______________