

CONSENT FOR TREATMENT / MEDICAL RELEASE AUTHORIZATION

NAME _____ Date _____

CONSENT FOR TREATMENT

I, the undersigned, hereby authorize Dr. Jensen and whomever he may designate as his assistant(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as is necessary. I also certify that no guarantee or assurance has been made to the results that may be obtained. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this 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 this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. *I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. I UNDERSTAND THAT LCC WILL VERIFY INSURANCE COVERAGE BUT THIS IS NOT A GUARANTEE OF PAYMENT OR HOW MY INSURANCE COMPANY WILL PROCESS MY INDIVIDUAL CLAIMS. I ALSO UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KNOW THE TYPE OF INSURANCE COVERAGE I HAVE.*

Patient's Signature _____ Date _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

Patient's Signature _____ Date _____

REQUEST FOR PAYMENT OF BENEFITS TO PROVIDER OF CARE

I hereby authorize the _____ Insurance Company/Insurance Administrator to pay by check, and for it to be mailed directly to Dr. Jan Jensen the expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

Patient's Signature _____ Date _____

ATTORNEY REPRESENTATION AND PROTECTION OF BALANCE

I the undersigned patient am directing my Attorney, to pay any outstanding bills of my settlement and, in effect, protecting any such balance. I hereby make and declare the instructions herein contained to be irrevocable. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for the doctor's additional protection and consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but will require me to make payment on a current status.

Guardian's Signature _____ Date _____

CONSENT FOR TREATMENT OF MINOR

I hereby authorize Jan Elkjaer Jensen, D.C., and whomever he may designate as his assistant(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as he deems necessary to my child (child's name)

_____.

Patient's Signature _____ Date _____

X-RAY/MEDICAL RECORDS RELEASE

I have requested the release of records of (patient's name) _____ which are a part of the records at (name of facility) _____. I hereby request and authorize you, your employees and agents to furnish to the person(s) listed below or anyone designated in writing by them, 11 copies of records, including copies of x-rays and photo static copies, abstracts or excerpts of all records and any other information they may request relating to any examination, treatment or opinion concerning any condition that I may have in the past, now have, or may have in the future. Please forward this to Dr. Jan Jensen at 1844 Fiddler Court, Suite B, Tallahassee, FL 32308

Patient's Signature _____ Date _____