



First State Physicians

Physical Medicine & Rehabilitation Center

Kevin J. McDermott, D.C.

CHIROPRACTIC TREATMENT CONSENT

I, _____, authorize and consent to all chiropractic treatments, including exams, diagnoses, x-rays, and physical therapy necessary for me, which are recommended by the First State Physicians Doctor. I also declare that today I am not pregnant.

Signature

Date

ASSIGNED BENEFITS

I _____, authorize insurance benefits with _____ (Insurance Name), to First State Physicians, for services provided to me and covered by this insurance policy. I agree to pay my part of the deductible or whatever my responsibility is.

Signature

Date

NOTICE OF RECEIPT OF PRIVACY IN THIS OFFICE

_____ I have read and understand the provisions listed in this office's privacy letter.

_____ I have read and understand the provisions listed in this office's privacy letter, but I do not want to sign certain things explained in the following line:

Signature

Date