Arizona Center For Family and Wellness Care

Dr. N. Edwin Weathersby, DC, CCSP, DAAPM, FIACA, FICCF
Chiropractic Rehabilitation

GENERAL CONSENT

The undersigned hereby consents to evaluation and treatment rendered according to the applicable standards of care. It is understood that options exist for treatment and all treatments are choices between risks and benefits. If the risks and benefits of proposed treatment are not clear to me, I understand that further information may be requested from N. Edwin Weathersby, DC. The information within this chart is confidential. I understand that all requests for release of my records must be in writing. Protected health information will be released with written authorization, with minimum disclosure necessary as related to your care. Please see Notice of Privacy Practices for more detailed information. I understand that I have a responsibility to communicate honestly with N. Edwin Weathersby, DC and to notify him of any changes in my health status.

FINANCIAL AWARENESS AND CONSENT

I understand I am financially responsible, whether or not my insurance company pays, for all charges incurred by me. I hereby assign my major medical insurance benefits, including private insurance and any other insurance plans, to Weathersby Chiropractic / Arizona Center for Family and Wellness Care. Any overpayment will be promptly refunded. I also authorize Weathersby Chiropractic to release any protected health information required to secure payment. Accounts over 90 days delinquent may be subject to a monthly finance charge of 1.5%, 18% annually.

Patient's Signature: _____ Date: _____

Responsible Party's
Signature (if patient is a minor): _____ Date: _____

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