Porter Chiropractic, PLLC
717 Wheatley Rd. Ashland, KY 41101

Dwain P. Porter, DC, MS
606-329-1148

Informed Consent

I hereby give consent to the performance of chiropractic care including adjustments and adjunct Chiropractic therapy as well as the use of diagnostics such as Radiological exams as needed to diagnose and treat.

I understand and am informed that, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise his judgment during the course of the procedure based upon the facts known and given to him.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment here at Porter Chiropractic, PLLC.

Direct Payment

*I hereby direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals and or other legal entities ("payers") which may elect or be obligated to pay benefits to me for any medical conditions, accidents, injuries, illnesses, past or future ("condition") to pay directly to and exclusively in the name of Porter Chiropractic, PLLC. Such sums may be owing to Porter Chiropractic, PLLC for charges incurred by me, including but not limited to charges for treatment, diagnostics, narrative reports, depositions, testimony, and any other charges incurred by me at the office. Any payment to another entity may be considered a fraudulent act. I deem Porter Chiropractic, PLLC to be the primary source of **all** payment benefits regarding the injury in which I am requesting treatment. If for any reason a payment is sent to another entity ie: Attorney for services rendered by Porter Chiropractic, PLLC., that payment must be immediately sent to Porter Chiropractic, PLLC without delay. Five percent interest daily will be charged beginning three days after release of the check. This document supersedes any other document that an attorney may have me sign. I must have my attorney read this document prior to patient / attorney contract.*

Release of Records: I hereby authorize the release of my records or copies of such to be sent to Dr. Dwain Porter, DC. A photocopy of this authorization shall be considered as effective and valid as the original.

Consent to Treat a Minor: I hereby authorize and request Dr. Dwain Porter, DC and his staff to administer such treatment deemed advisable, necessary or requested on the above minor. I agree to hold him free and harmless from any claims, suits for damages or complications which may result from such treatment.

X-ray's: I have the right to keep a copy in my possession my digital radiological exam. After three years x-ray's may otherwise be deleted.

Assignment and Instruction of Direct Payment to Doctor

I hereby instruct and direct my insurance company to pay by check or electronic check, made out and mailed directly to: **Porter Chiropractic PLLC 717 Wheatley Rd. Ashland, KY 41101**

******** Patient's Initial's_____ ******

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THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.
I understand that I am responsible for **any and all charges** invoiced by Porter Chiropractic, PLLC. I further understand that Porter Chiropractic, PLLC will as a courtesy electronically invoice my health insurance company but I am ultimately responsible for the charges incurred.
Porter Chiropractic, PLLC does not have the responsibility to research eligibility from my health insurance company. It is ultimately my responsibility to understand my contracted health insurance companies eligibility (in or out of network, modalities, office visits, etc.) for payment to Porter Chiropractic, PLLC. Any failure for my health insurance company, which includes state and federally funded insurance to remit payment for **any** Chiropractic services rendered will then become my responsibility to reimburse Porter Chiropractic, PLLC. I further understand that I am responsible for all co-pays, co-insurance, deductibles, or non-payments that may be applied by health insurance company.

If I do or do not have insurance coverage or my health insurance fails to provide payment for our services for any reason, I agree to pay for all professional services provided to me from Porter Chiropractic, PLLC. I also agree that if I do not pay in a timely manner Porter Chiropractic PLLC has the right to charge my account interest on any unpaid balance. A photocopy of this assignment shall be considered as effective and valid as the original. I am responsible for payment of treatment or claim if recoupment process by my third party insurance due to any error, attempts to reclaim money from the doctor. I am responsible for payment for all treatment and give consent for such treatment as performed by Dr. Porter, DC. I authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved. This supersedes all other policies and membership plans as related to patient and Porter Chiropractic, PLLC. I give full consent for Porter Chiropractic to act on my behalf to appeal any insurance third party payor if they refuse to pay my claim for any reason. <u>If insurance is rejected for any reason I am responsible for unpaid balance.</u>
Attention all Patients If your insurance company requires pre-certification for our patient procedures (i..e., MRIs, CT, lab, massage, treatment, etc.) or a referral from your primary care physician… it is your responsibility to know this and alert us that this needs to be done prior to any treatment or testing the doctor may order for you within or outside the office. If you fail to do this, we will not be responsible for any re-imbursement penalties for uncertified procedures. The patient will be responsible for payment of the balance due. You are responsible to contact us in writing for any changes of your address, name, status, ins. co. or plan or any other information currently on file. We will be happy to assist you in this process.

By signing below you will enable Dwain P. Porter, DC to become your Primary Care Physician. Porter Chiropractic, PLLC will as a courtesy bill insurance companies for all procedures performed. I give full authorization to Porter Chiropractic. PLLC to use my credit card as payment for patient responsibility debts due to non payment or deductable or co insurance or co-pay as necessary. I have received and or read the HIPPA notice of privacy practices. I will place my signature below in acceptance to all assignments on this page. I deem the examination and treatment I will receive from Dr. Dwain P. Porter, to the best of my knowledge is medically necessary.

Signature of policyholder	Social Security #	Date of Birth	Date

Signature of Claimant, if other than policyholder	Date