Midwest Healthcare Center
2 N. Country Club Rd., Ste. 3
Decatur, IL 62521
Phone: 217-423-1500
Fax: 217-423-1504

INFORMED PATIENT CONSENT AND RELEASE

I hereby authorize the doctor/provider (Midwest Healthcare Center) to examine and treat my condition as he/she deems appropriate through the use of Chiropractic Health Care, Physical Therapy, Massage Therapy, Acupuncture, and/or Nutritional Counseling, and I give authorization for these procedures to be performed. Also, I authorize the doctor/provider to consult with other professionals concerning my care and treatment.

I authorize my doctor to submit my x-rays for radiological interpretation to any doctor deemed qualified by my doctor. I authorize the release of medical information for billing of my insurance if applicable; and, I hereby consent to the release of any medical information necessary to process this claim and to request that payment of insurance benefits be made either to me or to my doctor if he/she accepts assignment.

I understand that Midwest Healthcare Center, its doctors and staff are accepting my case based on examination findings and believe the outlined treatment should produce change and/or improvement. However as with any diagnostic test, procedure, examination or doctor's care, I understand that a guarantee of improvement or complete recovery cannot be made and it is even possible that no change will occur. I further understand that in the practice of chiropractic, physical therapy, massage therapy, acupuncture, and nutritional counseling there are some risks including but not limited to fractures, disk injuries, strokes, dislocations, sprains-strains, drug interactions and reactions and/or other injuries or side effects which cannot be pre-determined.

I do not expect the doctor/provider to be able to anticipate and explain all risks and/or complications, and I wish to rely on the doctor/provider to exercise judgment during the course of the procedure(s) which the doctor/provider feels at the time is in my best interest.

Patients have the right to refuse treatment, but must be aware of the probable consequences of refusing treatment and/or failing to cooperate with the prescribed treatment. Should you refuse and/or fail to comply with prescribed treatment your provider will discuss specific consequences with you.

Having read this document fully, I give my full consent to the doctor/provider to render treatment on me or to the minor for whom I am legally responsible, by a health care provider of Midwest Healthcare Center. I have been informed by Dr. Penwell and his office staff of the type of treatment to be provided, and any known risks of that treatment. I hereby consent to and request treatment as my voluntary act.

______________________________	______________________________
Printed Name of Individual	Signature of Individual
______________________________	______________________________
Signature of Legal Representative	Relationship
______________________________	______________________________
Date Signed	Witness

Revised 01/01/08

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AGREEMENT TO BILL THIRD PARTY
(AND AGREEMENT TO PAY IF THIRD PARTY DOES NOT PAY)

I authorize payment of any medical benefit from third parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you, based upon the charges submitted for products and services rendered.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me (the patient). Furthermore, I understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment. The facility will prepare any necessary reports and forms to assist me in making collections from the insurance company and any amount authorized to be paid directly to the facility will be credited to my account upon receipt. I also understand that if I suspend or terminate my care and understand and agree that I will be charged $25.00 for balances 30 days old if no payment is received within 10 days of receipt of my statement. I further understand that any balance over 90 days may be turned over to a collection agency or attorney. I agree to be responsible for all reasonable fees necessary for the collection of the delinquent amount including, but not limited to, collection agency fees up to 50% of the balance due, costs, and reasonable attorney fees.

Medicare Patients understand that Medicare does not cover radiologist services, but that supplemental insurance may, and supplemental insurance will be billed if applicable. Whether or not I am a Medicare patient, I understand and agree that the amount paid to the doctor for x-rays is for examination only, and not for the x-ray film itself. Accordingly, I agree that the x-ray negatives will remain the property of the facility, where they may be viewed by me or an authorized representative at any time. Finally I agree that if a copy of my x-ray or x-rays is needed, I will pay a reasonable charge for the original negative or a copy, if I require it to be removed from my doctor's office.

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