



SOUTH ORANGE REHABILITATION & WELLNESS

SOUTH ORANGE REHABILITATION & WELLNESS AGREEMENT

CONSENT FOR MEDICAL TREATMENT

I hereby authorize South Orange Rehabilitation & Wellness to administer and perform procedures deemed necessary or advisable in the treatment of this patient.

Patient initial: _____

CONFIDENTIALITY

Patient privacy and confidentiality is important to us. Due to the nature of our facility (open gym area), conversations maybe overheard by other patients and some information may be shared. If you have information that you would like to discuss with the therapist in private, please be sure to bring this to their attention. If you have any other concerns about confidentiality, please be sure to let us know.

Patient initial: _____

AGREEMENT FOR FINANCIAL RESPONSIBILITY

I hereby authorize payment directly to South Orange Chiropractic Center, LLC, by my insurance carrier, of benefits otherwise payable to me, such payment not to exceed regular charges for the services performed. I understand that I am financially responsible to South Orange Rehabilitation & Wellness, LLC / South Orange Chiropractic Center for charges not paid under this agreement.

A fee of 1.5% of the existing balance may be added each month to all accounts over 60 days old. In the event your account is turned to collections, an additional \$200.00 handling fee will be applied.

Patient initial: _____