

Kellerman Chiropractic Center
221 N. Anderson St, Sullivan, IL 61951
217-728-8888

Authorization To Treat

I hereby authorize Dr. Nicolas L. Kellerman to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care and/or acupuncture, and I give authorization for these procedures to be performed. It is understood and agreed the amount paid to the doctor for the x-rays is for the examination only and the x-ray negatives will remain the property of the office, being on file where they may be seen at any time while a patient of this office. The doctor will not be held responsible for any pre-existing medical condition nor any medical diagnosis. Also, I authorize Dr. Kellerman to consult with other professionals concerning my care and treatment.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself (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. Dr. Kellerman's office 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 Dr. Kellerman's office will be credited to my account upon receipt. In the event that my account is past due I agree to be charged 1.75% interest per month or 21% annual interest on any balance over 30 days or 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 account including, but not limited to, collection fees of up to 50% of the balance due, costs, and reasonable attorney's fees.

I understand that Dr. Kellerman may submit my x-rays for a radiologist's interpretation to **DR. C. M. BECKER OF CENTRAL ILLINOIS DIAGNOSTICS**. I authorize the release of medical information that they can bill my insurance if applicable. I also assign benefits for this service to **CENTRAL ILLINOIS DIAGNOSTICS** and understand that I am responsible for any unpaid balance.

I certify that I have read and understand the above agreement, that the risks and possible complications of chiropractic treatment have been explained to me, and I understand them.

Print Name: _____

Patient Signature: _____ **Date:** _____

~~**MEDICARE PATIENTS ONLY:** I understand Medicare does not cover the radiologist's service but supplemental insurance will be billed if applicable.~~

Patient Signature: _____ **Date:** _____