Madeira Chiropractic & Rehabilitation, PC

124 Kennebec Drive Chambersburg, PA 17201
Phone: (717) 263-8919 Fax: (717) 263-2655

Consent for treatment

I hereby authorize employees and agents: including physicians and physician assistants, of Madeira Chiropractic & Rehabilitation to render routine chiropractic and/or physical therapy care to the patient indicated on this form and to fulfill the orders of the physicians; including consultants, associates, and assistants of the physicians' choice.

The duration of this consent is indefinite and continues until revoked in writing or, in the case of minor children, until the child reaches the age of eighteen. I understand that by not signing this consent, the patient will not be provided medical care except in case of emergency.

If patient is a minor:

I give my consent and authorization for Madeira Chiropractic & Rehabilitation to provide medical evaluation and treatment to my child _____ when I am not available.

Insurance Authorization:

I hereby authorize Madeira Chiropractic & Rehabilitation to bill the insurance company for services provided and that payment is made directly to the providing doctor's office. This authorization is valid until written notice is provided to cancel the authorization.

Signature of Patient, Parent, or Legal Guardian Date

Print Name: _____Relationship to the patient _____