HORIZON HEADACHE CENTER
an integrative, non-narcotic approach to headache management

2365 Harrodsburg Road Suite B100
Lexington KY 40504
Phone: 859-263-2222
Fax: 859-263-0020
Email: info@horizonheadache.com
www.horizonheadache.com

Consent for Treatment Form

I hereby give my permission for Horizon Headache Center, PLLC to render treatment to me/my dependent. I understand that I will be given all available pertinent information prior to the treatment being rendered. I will be given the opportunity to ask questions and to have them answered to my satisfaction. I understand that I may decline treatment at any time

_____ _____

SIGNATURE (Parent/Guardian) DATE

CONSENT TO RELEASE/OBTAIN MEDICAL INFORMATION:

Permission is hereby granted to Horizon Headache Center, PLLC to release information to my insurance company, employer, attorney, workers compensation carrier, physician/facility referred to for further treatment and/or my referring/family physician. Permission is hereby granted to any facility where I have previously been treated to release medical records to Horizon Headache Center, PLLC.

_____ _____

SIGNATURE (Parent/Guardian) DATE

AUTHORIZATION FOR PAYMENT OF BENEFITS:

I authorize Horizon Headache Center, PLLC to bill my health insurance for services rendered. All payments received will be applied to my balance. I will be responsible for all co-pays/co-insurance and deductibles that may apply. Although Horizon Headache Center, PLLC will help verify and assist me in understanding my benefits, it is ultimately my responsibility and I will not hold Horizon Headache Center, PLLC responsible for any misinterpretation of insurance benefits. I understand that any charges not paid by my insurance company are my responsibility, and are due and payable by me.

_____ _____

SIGNATURE (Parent/Guardian) DATE