AUTHORIZATIONS AND RELEASES FOR CHIROPRACTIC PHYSICIAN

Name: ______________________________ Case No: ______________ Date: ______________

CONSENT FOR TREATMENT

I, the undersigned, a patient in this office, hereby authorize Dr. ______________________ (Chiropractic Physician) and whomever may be designated as an assistant to administer treatment as is necessary.

I also certify that no guarantees or assurances have been made to me as to the results that may be obtained.

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from any insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my credit. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Lastly, I understand and agree to pay interest on any unpaid balance that is due at the conclusion/termination of the treatment administered at a rate of 1.5 percent interest per month (18 percent APR) or as allowed by law, until the balance is fully paid.

Patient's Signature: ______________________ Date: ____________ Witness: ______________________

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

I authorize the release of any health care information necessary to process my insurance claim(s) and also certify that all insurance information given to Chiropractic Physician is correct and complete.

Patient's Signature: ______________________ Date: ____________ Witness: ______________________

REQUEST FOR PAYMENT OF BENEFITS TO PROVIDER OF CARE

I hereby authorize ______________________ Insurance Company/Insurance Administor to pay by check and for it to be mailed directly to Chiropractic Physician with the expense benefits allowable and otherwise payable to me under my current policy as payment toward the total charges for professional health care services rendered. I have agreed to pay, in a current manner, any balance of said professional charges. I hereby agree that this office be given the power of attorney to endorse/sign my name on any and all drafts for payment of my bills.

Patient's Signature: ______________________ Date: ____________ Witness: ______________________

ATTORNEY REPRESENTATION AND PROTECTION OF BALANCE

I, the undersigned patient am directing my attorney, ______________________, to pay any outstanding bills out of my settlement and, in effect, to protect any such balance. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for the doctor's protection and consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover any fees for services. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but will require me to make a payment on a current status.

I am also directing my attorney to pay any outstanding bills with any interest owed as outlined in the "Consent for Treatment" out of my settlement and, in effect, protecting any such balance. I fully understand that I am directly responsible for all health care bills and any interest owed and that this agreement is made solely for the doctor's additional protection and consideration of his awaiting payment.

Patient's Signature: ______________________ Date: ____________ Witness: ______________________

CONSENT FOR TREATMENT FOR MINOR

I hereby authorize Chiropractic Physician and whomever may be designated as an assistant to administer treatment as deemed necessary to my

______________________ (indicate relationship of child) named ______________________

Guardian's Signature: ______________________ Date: ____________ Witness: ______________________

X-RAY/HEALTH CARE RECORDS RELEASE

I have requested the release of my x-rays and/or health care records which are part of the records at ______________________ (Clinic). In consideration of the foregoing, I hereby release Clinic from responsibility arising from release of said materials, once delivered. I hereby acknowledge receipt of said materials or request that these materials be sent to the offices of Chiropractic Physician.

Patient's Signature: ______________________ Date: ____________ Witness: ______________________