

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate.

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

Patient's Signature

Date

Guardian or Spouse's Signature Authorizing Care

Date

Who should receive bills for payment on your account?

Patient

Spouse

Parent

Worker's Comp

Auto Insurance

Medicare

Medicaid

Personal Health Insurance

Ownership of X-ray Films.

It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negatives will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient of this office.

IN AN EMERGENCY, CONTACT:

Name _____

Relationship _____

Work Phone _____

Home Phone _____

ABOUT MY INSURANCE

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

Insurance Co. Name _____ Group Number (Plan, Local, Policy #) _____

Address _____ Phone _____

ABOUT THE INSURED PERSON

Name _____ Insured's Social Security # _____

Relation _____ Date of Birth _____

Employer _____