

INSURANCE INFORMATION

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account on receipt. 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. If balance becomes delinquent and suit is filed, I agree to pay all collection costs, and attorney's fees in addition to above fees. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize the doctor and whomever he may designate as his assistant to administer treatment, physical examination, X-Ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; and I further authorize him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including , and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

Patient's Signature

Date ___/___/___

Spouse or Guardian's

Signature _____ Date ___/___/___