## Authorization and Release

Name: ____________________________________ Case #______________________________________

✓ ***Consent for Treatment***

I, the undersigned, hereby authorize the Doctors of Foothills Chiropractic Wellness Center and whomever they may designate as their assistant(s) to perform diagnostic test, including but not limited to radiographs, and to administer treatment as necessary.

I, also, certify that no guarantee or assurance has been made to the results that may be obtained.

I understand and agree that accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company that my account 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 account. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment.

Patient's Signature ____________________________Date ___________________Witness__________________________________

✓ ***Authorization to Release Medical Information***

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this client is correct and complete.

Patient's Signature ____________________________Date ___________________Witness__________________________________

✓ ***Request for Payment of Benefits to Provider of Care***

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

Patient's Signature ____________________________Date ___________________Witness__________________________________

✓ ***Attorney Representation and Protection of Balance***

I, the understand patient am directing my Attorney, ___________________, to pay any outstanding bills out of my settlement and, in effect, protecting any such balance. I hereby make and declare the instructions herein contained to be irrevocable. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for the doctor's additional protection and consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. 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.

✓ ***Consent for Treatment of Minor***

I hereby authorize the Doctors of Foothills Chiropractic Wellness Center and whomever they may designate as their assistant (s), to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as they deem necessary to my ___________________(indicate relationship of child) ____________________________(child's name)

Patient's Signature ____________________________Date ___________________Witness__________________________________

✓ ***X-Ray/Medical Records Release***

I have requested the release of records of (patient's name) ______________________________which are part of the records at Foothills Chiropractic Wellness Center.

I hereby request and authorize you, your employees and agents to furnish them to the person(s) listed below or anyone designed in writing by them, all copies of records and reports, including copies of x-rays and Photostat copies, abstracts or excerpts of all records and any other information they may request relating to any examination, treatment or opinion concerning any conditions that I may have had in the past, now have, or may have in the future.

Please forward this to: (Name) _________________________________(Address)_______________________________

Patient's Signature_______________________________Date__________________Witness______________________