AUTHORIZATION FOR CHIROPRACTIC CARE

Please discuss any questions or concerns with REBECCA S. EAGAN D.C before signing this authorization.

I hereby authorize: REBECCA S. EAGAN D.C., and whomever she may designate, to administer chiropractic care as is necessary, and to perform therapy and adjustments that are considered therapeutically necessary on the basis of findings during the course of treatment. I hereby certify that I have read and fully understand that above Authorization for Chiropractic Care, its advantages and possible complications, if any, as well as possible alternative modes of treatment, which were explained by REBECCA S. EAGAN D.C. I also certify that no guarantee or assurance has been made by REBECCA S. EAGAN D.C. or her staff as to the results that I may obtain from the prescribed chiropractic care.

Date Signed:______________________ Doctor's Signature:______________________

Patients Name:______________________ Patient's Signature:______________________

Guardian Signature:______________________ Witnessed:______________________

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

A. I authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment below.

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Patient signature or autorized person acting on patient's behalf *Date*

B. I authorize payment of any medical benefits from ______________________________

to be paid directly to ______________________________ for any services rendered to me.

Doctor or Clinic Name

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Patient signature or autorized person acting on patient's behalf *Date*

AUTHORIZATION AND ASSIGNMENT

In consideration of you providing care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney, out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole, or in part, upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me, or to you, for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action either in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. It is understood, however, that until all reasonable efforts have been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance companies proceeds, whether it be all or part of what is due, I personally owe you.
4. In addition to the above, I hereby waive the statue of limitations on collection and/or recovery in this state/province of ______________________.
5. I further agree that this Authorization and Assignment is irrevocable until all monies owed______________________ *Doctor or Clinic Name* ______________________, are paid in full.

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Patient signature or person acting on patient's behalf *Date*

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Staff Signature *Date*

RECORDS RELEASE

To ______________________, I hereby authorize you to release to ______________________ any Information including the diagnosis and records of any examination or treatment rendered to me during the period between ______________________ and ______________________.

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Patient signature or person acting on patient's behalf *Date*

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Staff/Witness Signature *Date*