Patient _____ ID# _____

ASSIGNMENT OF BENEFITS

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to **ALTERNATIVE HEALING CHIROPRACTIC CENTER, PLLC** the professional expense benefits allowable, and otherwise payable to me under my current policy as payment toward the total charges for professional services rendered by **ALTERNATIVE HEALING CHIROPRACTIC CENTER, PLLC.**

A photocopy or fax of this assignment shall be considered as effective as the original.

Initials _____

RELEASE OF INFORMATION

I authorize **ALTERNATIVE HEALING CHIROPRACTIC CENTER, PLLC** to release any information pertinent to my case to any insurance company, adjuster or attorney involved in this case; and hereby release **ALTERNATIVE HEALING CHIROPRACTIC CENTER, PLLC** of any consequences thereof.

A photocopy or fax of this assignment shall be considered as effective as the original.

Initials _____

X-RAY RECORDS

I acknowledge and certify that all x-ray films in the possession of **ALTERNATIVE HEALING CHIROPRACTIC CENTER, PLLC** will remain a part of my permanent record. Fees paid for x-rays are for analysis only. The film itself is the property of **ALTERNATIVE HEALING CHIROPRACTIC CENTER, PLLC.** Copies may be made if necessary.

Initials _____

FINANCIAL RESPONSIBILITY

I agree to be financially responsible for all charges incurred at this clinic including my insurance deductible, copay and any services rejected by my insurance company. I further agree and understand that all personal balances are to be paid in full by the close of business on Friday unless prior arrangements have been authorized. Interest, late fees and collection fees will be assessed on all accounts 30 days past due.

I agree to and will abide by all the terms stated above.

Patient signature _____ Date _____

Guardian or spouse's signature authorizing care _____

PLEASE CHECK WITH YOUR INSURANCE COMPANY ON YOUR CHIROPRACTIC BENEFITS. WE ARE NO RESPONSIBLE FOR THIS INFORMATION.