



ASSIGNMENT

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to this clinic, the professional or medical expense benefit allowable and payable under my current insurance policy as payment toward the total charges for my professional services rendered in this office. **A photocopy of this assignment shall be considered as effective and valid as the original**

RELEASE OF INFORMATION

I authorize Rae Chiropractic LLC DBA Prescott Chiropractic to release any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I hereby forever release Prescott Chiropractic, its agents and employees of any consequence thereof.

RELEASE OF MEDICAL RECORDS

You are hereby authorized and instructed to release to Carina Patnode, D.C., Marisa Hamre, D.C., Casey Webber, D.C., Rae Chiropractic LLC DBA Prescott Chiropractic all information/records concerning treatment and/or involvement in the care of my health.

FINANCIAL RESPONSIBILITY

I agree to be financially responsible for all charges to Prescott Chiropractic including my insurance deductible, copayment, and any services rejected by my insurance company or any other entity responsible for payment.

REFERRALS/AUTHORIZATIONS

I agree to pay for all services when a referral from my primary care physician was not received prior to being seen, or authorization from my insurance company was not obtained at the time of my visit.

ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I have received a copy of Prescott Chiropractic financial and consent policies (found on website) and I fully understand and agree to each item listed.

I have read, understood, and accepted the items listed above.

Patient/Guardian Signature

Date