DC Canyon Health and Wellness Center

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any information you deem necessary concerning my health condition to any insurance company, attorney or adjuster for processing my claims for reimbursement charges incurred at this office.

I authorize my insurance carrier to pay directly to DC Canyon Health and Wellness the expenses that I have accrued during my visit at this office and at future visits. I fully understand that if I receive the check or other drafts of payment from the insurance company that I will deliver the check immediately to the office. To then be applied to my account for the services rendered.

I agree that DC Canyon Health and Wellness has full power of attorney to endorse/sign my name on any/all checks for payment of any debt owed to this office.

I fully understand and agree that my insurance policy is an arrangement between myself and the carrier. I will be responsible for expenses not paid by insurance. I understand and agree that I will be charged for missed appointments and am responsible for those charges.

A photocopy of this form shall be as valid as original.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and /or licensed doctors of chiropractic who now or in the future treat me while employed by, working of associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disk injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all the risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, and does so in my best interest.

I have been shown and offered a copy of the "Notice of Privacy Practices" form.

I have read, understand and agree with authorization and assignment of benefits and have been offered a copy.

TO BE COMPLETED BY PATIENT

Patient's Name__________________________________ Signature of Patient_____________________________________

Date Signed______________________Witness to Patient's Signature____

TO BE COMPLETED BY PATIENT'S REPRESENTATIVE IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED

Patient's Name______________________________Name of Representative______________________________________

Date Signed____________________Signature of Representative____

Relationship or Authority of Patient's Representative____

Translated by___________________________________Date____

Doctor's Name_______________________Signature_______________________________________Date_______________