

BACK ON TRACK CHIROPRACTIC LLC

Patients Name _____

Date _____

Assignment of Insurance Benefits

I authorize my insurance companies to pay all medical benefits directly to Back on Track Chiropractic for chiropractic services rendered to me. I assign the right to pursue reimbursement, appeal decisions, and take appropriate legal action to secure payment from my insurance company directly to Back on Track Chiropractic. A copy of my signature on this form is as valid as the original.

Signed _____

Date _____

Responsibility for Payment

I clearly understand and agree that all services rendered to me by this office are charged directly to me and that I am responsible for payment. I understand that Health and Accident Insurance policies are an arrangement between an Insurance Company and myself. I understand that if this office agrees to accept assignment of insurance benefits in my case that Back on Track Chiropractic will prepare necessary forms and reports to assist me in making collection from the Insurance Company and that any amount paid will be credited directly to my account upon receipt. I recognize that this office accepts assignment only as a courtesy to me and I remain responsible for payment. I understand that if I terminate my care and treatment any fees for professional services will be immediately due and payable.

Signed _____

Date _____

Records Transfer Request

I hereby authorize the release of my MEDICAL RECORDS & REPORTS or copies of such and request that they be transferred to Back on Track Chiropractic/James L. Boas, D.C. I authorize the release of any medical information from BOTC to my other Medical Providers, attorney and/or anyone else involved in my case.

Signed _____

Date _____

Authorization to Treat Minor Child

I _____ authorize Dr. James L. Boas, his staff, or any person that deems qualified to provide Chiropractic evaluation and Treatment to my minor child.

Signed _____

Date _____