## AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

Patients Signature: ______________________ Date __________________ Witness________________

## REQUEST FOR PAYMENT OF BENEFITS TO PROVIDER OF CARE

I here by authorize the ____________________ Insurance Company/Insurance Administrator to pay by check and for it to be mailed directly to BACK TO HEALTH CHIROPRACTIC CLINIC the expense benefits allowable, and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered, and I have agreed to pay. In a current manner, any balance of said professional charges. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

Patients Signature: ______________________ Date __________________ Witness________________

## CONSENT FOR TREATMENT

I, the undersigned, a patient in this office hereby authorize Dr. Roger A. Marquardt and whomever he may designate as his assistant(s) to administer treatment as is necessary.

I also certify that no guarantee or assurance has been made to the results that may be obtained.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Patients Signature: ______________________ Date __________________ Witness ________________