AUTHORIZATION AND ASSIGNMENT

X-RAY AUTHORIZATION

I, the undersigned, state that to the best of my knowledge, that I am not pregnant; nor do I hold ***Galligan Family Chiropractic*** liable for any circumstances which may arise from X-ray radiation.

I have read and understand the above and release Galligan Family Chiropractic from the liability of the above procedures.

I also understand that the cost of the x-rays is for the analysis is and the ex-rays are the property of the chiropractic office.

Date: _____ Signed: _____

Witnessed: _____

ASSIGNMENT OF PAYMENT

My attorney/insurance carrier are hereby requested and authorized to pay direct to ***Galligan Family Chiropractic*** any monies due them on account, the same to be deducted from any settlement made on my behalf.

Further, I agree to pay ***Galligan Family Chiropractic*** the difference, if any between the total amount of charges and the amount paid by the attorney/insurance carrier. I understand that verification of benefits is not a guarantee of payment and ultimately I am responsible for payment. It is further understood that I, the undersigned, agree to pay ***Galligan Family Chiropractic*** the full amount of charges, should my condition be such that it is not covered by my policy or if for any reason the insurance carrier refuses to pay my claim.

Are you insured? YES NO Company:_____

Person Responsible for Payment: _____

Signature of Patient: _____

Date: _____

Witnessed: _____