RAUCH CHIROPRACTIC **37300 Dequindre Road Suite 112, Sterling Heights, MI 48045**

Authorization. Assignment. Acknowledgement and Understanding.

AUTHORIZATION TO RELEASE INFORMATION: You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you (Rauch Chiropractic, including designated associates and assistants) and hereby release you of any consequence thereof.

ASSIGNMENT OF PAYMENT: My attorney and/or insurance company are hereby requested to pay directly to Rauch Chiropractic any monies due him on account, the same to be deducted from any settlement made on my behalf. Furthermore, it is understood that I, the undersigned, agree to pay the full amount of the charges, should my condition be such that is not covered by my policy or if any reason the insurance company and/or attorney refuses to pay my claim.

MEDICARE ASSIGNMENT: I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

CONSENT TO CARE FOR A MINOR: I hereby authorize Rauch Chiropractic to administer care as deemed necessary to: ______________________________

I hereby acknowledge that I am receiving (or about to receive) health care services at Rauch Chiropractic and that I have been advised that you are willing or wait for payment for these services provided that there continues to be a reasonable chance that payment will be made either by insurance proceeds or out of the settlement of a liability case.

I understand that if it is determined either:

A) There is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment or Rauch Chiropractic or to make other provisions for the protection of the interest of Rauch Chiropractic, or
B) If a liability claim exists and my attorney refuses to agree to protect the interest of Rauch Chiropractic, or if I have not engaged the services of an attorney:
    a. Then payment of services at Rauch Chiropractic will be made on a current basis and my bill paid in full as soon as my liability claim is settled or the passage of three months from my last treatment, whichever occurs first.

______________________________ ______________________________

Patient name (please print) Patient Signature

______________________________ ______________________________

(Date Signed) Witness

Professional Courtesy

As a professional courtesy, I authorize Rauch Chiropractic to provide my medical doctor with a report for my medical record. Please send to:

______________________________ ______________________________

Name of Medical Doctor Office Name

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Office Address and Phone Number

______________________________ ______________________________

(Patient Name) (Patient Signature)