SPINAL HEALTH GROUP
Caring is the heart of our commitment

AUTHORIZATION FORM

Patient Name_____ **SSN:**_____

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND ACUPUNCTURE
I hereby request and consent to the performance of acupuncture, chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me by the doctor of chiropractic or anyone working in this clinic authorized by the doctor. **INITIALS**_____

I understand that in the practice of chiropractic, as in all health care, there are some very slight risks to treatment, including but not limited to muscle strains and sprains, disc injuries, and cerebrovascular accidents. I rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time is in my best interests. **INITIALS**_____

RESPONSIBILITY OF BILL
The undersigned hereby accepts full financial responsibility for charges and services rendered to the patient. The undersigned understands that services are rendered and charged to the patient and not to the insurance company. SPINAL HEALTH GROUP cannot accept total responsibility for collecting an insurance claim or negotiating a disputed settlement. The undersigned also agrees that this obligation shall exist regardless of private contractual agreement between the patient and any insurance carrier, attorney, or third party not signing this agreement. Financial responsibility will also include charges and services not covered by insurance for which payment is denied through any utilization review or precertification procedures. **INITIALS**_____

RELEASE OF INFORMATION AND PAYMENT OF INSURANCE BENEFITS TO PROVIDER
I hereby authorize SPINAL HEALTH GROUP to release medical and financial data to my insurance carriers and attorney. I hereby irrevocably authorize payment of the medical benefits otherwise payable to me to be made payable and mailed directly to SPINAL HEALTH GROUP for professional services rendered. NO OTHER THIRD PARTY, including my attorney, should receive payment of my bills except this office for the remainder of this claim. It will be assumed and relied upon that the insurance carrier has agreed to and acknowledges medical coverage and will send payments directly to this office. **INITIALS**_____

CONSENT FOR THE TREATMENT OF MINOR CHILD
Consent is hereby given by the undersigned for chiropractic treatment and diagnostic studies as ordered by the doctor and performed by the technical staff of SPINAL HEALTH GROUP. The undersigned states that he/she is the patient's legal guardian. **INITIALS**_____

Patient, Agent, or Representative	Relationship	Witness	Date