Hazlewood Chiropractic Clinic
Authorization Form

Patient Name ____________________ SSN _____ - _____ - _____

RELEASE OF INFORMATION
I hereby authorize HAZLEWOOD CHIROPRACTIC CLINIC to release medical and financial data to my insurance carriers and attorney. **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. HAZLEWOOD CHIROPRACTIC CLINIC 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 recertification procedures. **INITIALS __________**

CONSENT FOR 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 HAZLEWOOD CHIROPRACTIC CLINIC. The undersigned states that he/she is the patient's legal guardian. **INITIALS ________**

AUTHORIZATION FOR PAYMENT OF INSURANCE BENEFITS TO PROVIDER
I hereby irrevocably authorize payment of medical benefits otherwise payable to me to be made payable and mailed directly to HAZLEWOOD CHIROPRACTIC CLINIC 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 _________**

SUBROGATION AND RIGHTS OF REIMURSEMENT AGREEEMENT
If I or one of my covered dependents receive benefits under my health insurance carrier, hereinafter referred to as Carrier, due to an injury or illness as a result of the acts of a third party, I agree to repay the Carrier any amount of money that I receive from third party or its insurer as compensation for such injuries up to the amount paid out by the Carrier. I understand that this includes the insurer or other agent or if I enter into any form of settlement regarding an accident which I or my covered dependents are injured as a result of the acts of a third party. I will do whatever is reasonable needed to secure the Carriers rights and shall do nothing to damage such rights. I will abide by this agreement only if my health insurance policy contains language that gives the health insurance carrier subrogation and rights of reimbursement. **INITIALS _____**

___________________________ _______________ _____________ __________
Patient, Agent, or Representative Relationship Witness Date