CHIROPRACTIC AUTHORIZATION RELEASE & EXPLANATION

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

A. I authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment below:

_____
Patient signature or authorized person acting on patient's behalf Date

B. I authorize payment of any medical benefits from_____
to be paid directly to Scott Chiropractic Clinic for any service rendered to me.

_____
Patient signature or authorized person acting on patient's behalf Date

AUTHORIZATION AND ASSIGNMENT

In consideration of you providing care for me, I agree to the following:

1. 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.
2. I authorize the **direct payment to you** of any sum I now or hereafter owe you by my attorney, out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole, or in part, upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me, or to you, for the charges made for you services **refuses to make such payment** upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent date) and authorize you to prosecute said action either in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. It is understood, however, that until all reasonable efforts have been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance companies proceeds, whether it be all or part of what is due, I personally owe you.
4. In addition to the above, I hereby waive the statue of limitations on collection and/or recovery in this state of Tennessee.
5. I further agree that this Authorization and Assignment is irrevocable until all monies owed Scott Chiropractic Clinic, are paid in full.

_____
Patient signature or person acting on patient's behalf Date

_____
Staff Signature Date

RECORDS RELEASE

To Scott Chiropractic Clinic, I hereby authorize you to release to _____ any information including the diagnosis and records of any examination or treatment rendered to me during the period between _____ and_____.

_____
Patient signature or person acting on patient's behalf Date

_____
Staff Signature Date