

SAWYER FAMILY CHIROPRACTIC

Releases

I hereby request and consent to receive chiropractic services, including, but limited to, adjustments, various manual and mechanical procedures, various modes of therapy, for me (or for the patient named below, for whom I am legally responsible) by Dr. Sawyer who now or in the future treat me. I authorize Dr. Sawyer and Staff to request medical records as needed from any source.

Initials _____

I clearly understand that all service rendered to me are charged directly to me and that I am personally responsible for payment. I authorize and assign any benefits to be paid directly to the Doctor's Office. Any payments will be immediately credited to my account upon receipt. I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered to me will be immediately due and payable.

Initials _____

Kindly furnish my doctors, insurance company, attorney and any other involved parties or their representatives all information you may have regarding my condition while under your treatment or observation, including but not limited to the history obtained, X-Ray, testing, physical findings, diagnosis and prognosis.

Initials _____

If using insurance, I understand that I am responsible for my co-pays, co-insurance, and deductibles that are apart of my insurance plan. I agree to pay for any charges that my insurance company does not see as "medical necessary" or denied charges.

Initials _____

I have read and understood the above information:

Patient/Guardian Name: _____

Patient/Guardian Signature: _____ Date: _____