



**McLeod Chiropractic**  
Eastpointe/ Shelby/ Waterford  
877-532-4476 · Michiganchiropractors.com

- 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 result of professional services rendered by you and I hereby release you of any Consequence thereof.*
- ASSIGNMENT OF PAYMENT:** *My attorney and/or insurance company are hereby requested to pay direct to the doctor listed below, any monies due him on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay the difference if any, between the total amount of his charges and the amount paid him by the attorney and/or insurance company. It is further understood that I, the undersigned, agree to pay the full amount of his charges should my condition be such that is not covered by my policy or if for any reason the insurance company and/or attorney refuses to pay claim.*
- MEDICARE ASSIGNMENT:** *I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carries any information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of the original and request payment of medical insurance benefits wither to myself or to the party who accepts assignment below.*
- CONSENT TO CARE FOR MINOR CHILD:** *I hereby authorize the doctor listed below and whoever he may designate as his assistants to administer chiropractic care he deems necessary to \_\_\_\_\_*

*Acknowledgement and understanding*

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

*I understand that if the determined either:*

- A.) That there is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment to the doctor, or make other provisions for the protection of the interest of the doctors or,*
- B.) If a liability claim exists and my attorney refuses to agree to protect the interest of the doctor, or if I have not engaged the services of an attorney then payment of services rendered by the doctor at McLeod 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.*

\_\_\_\_\_  
*Signature of Patient*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Witness*