Select-Care Chiropractic, PC
Nutrition • Chiropractic • Wellness
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AUTHORIZATION FOR RECORDS RELEASE

This authorization or photocopy hereof, will authorize Select-Care Chiropractic, P.C. to furnish and/or receive all information regarding my health care while under their observation or treatment, including the history obtained, diagnostic testing, physical findings, diagnosis and prognosis from the following offices/ Doctors:

_____
(PRINT PATIENT NAME)

_____
(PATIENT SIGNATURE)

____ Chiropractor: _____

____ Primary Care Physician: _____

____ Pain Clinic: _____

____ Neurologist: _____

____ OBGYN/Midwife: _____

____ X-rays, MRI, CT, EMG (where): _____

____ Surgical Notes (not indicated above): _____

____ Other: _____

Financial Policy

I, _____ (patient name), am insured by _____ (insurance company name) and am seeking care in this office.

I understand that if my insurance company does not cover certain aspects of my care (copay, co-insurance, deductible, out-of-network benefits, fees related to terminated coverage, or any other allowable fees), I will be financially responsible.

I also understand that if I do not make payments to Select-Care Chiropractic, P.C. in a timely manner, late fees may occur and my account will be forwarded to a Collections Agency.

Thank you for your understanding.

_____(PATIENT SIGNATURE) _____(DATE)