

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____ I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for four years.

X-RAY ASSIGNMENT AGREEMENT

_____ I understand that the services of a chiropractic radiologist are being utilized to insure the highest quality interpretation of my x-rays. I acknowledge that these services are separate from those of the clinic where I am receiving chiropractic care, and that the charges for these services will be submitted to my insurance carrier, Workers' Compensation carrier and/or to my attorney in the case of personal injury.

In the event that I receive payment for these services, I agree to promptly remit payment to American Radiological Services (ARS).

I assign my insurance benefits and rights to payment to ARS to the extent of their charges, and authorize them, or their agents, to bill and release information to my insurance company, attorney, and/or any third-party payer to provide ARS or their agents with any information concerning my claim, their services, and/or payment for the services provided.

By my signature below, I acknowledge that I have read, understand, and agree to the above provisions, and I assign my insurance benefits as described above.

TREATMENT AUTHORIZATION

_____ I understand that if I am accepted as a patient by Alterman & Johnson, Family Chiropractors, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risks regarding chiropractic care will be explained to me upon my request.

_____ I understand that due to the nature of the massage therapy schedule, a call is required the day before to cancel a massage appointment, otherwise a 50% charge will be posted to my account.

_____ I hereby authorize payment directly to this office for professional services rendered and I shall be personally responsible for any unpaid balances. I hereby authorize the attending doctor to release any information concerning my examination or treatment.

Print Name Date

Signature (Patient or Parent/Guardian)

AUTHORIZATION FOR TREATMENT OF MINOR

I hereby authorize Alterman & Johnson, Family Chiropractors to administer treatment as they deem necessary to my child _____.

Parent/Guardian Signature Date