Authorization and Assignment

In consideration of your undertaking to treat me, I agree to the following:

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.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I authorize payment of medical benefits directly to Dr. Robert E. Monk for the services rendered to me. In any instance of overpayment, I realize that the money will be either credited toward my account or refunded to me.

I hereby authorize the Doctor to treat my condition as he deems appropriate through the use of manipulation throughout my spine, and if necessary, the use of therapy.

It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing, medically diagnosed conditions, nor for any medical diagnosis.

I have read, understand, and accept the information on this page.

___________________________________	___________________________________
Patient’s Signature	Date
___________________________________	___________________________________
Witness	Provider