Harris Chiropractic Center INC.
1025 N. Main St
Franklin IN, 46131

AUTHORIZATION, ASSIGNMENT & RELEASE FORM

AUTHORIZATION & ASSIGNMENT

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

1. 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.
2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney out of the proceeds of any settlement of my case, and/or by insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you. I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent date) and authorize you to prosecute and action in my name is you see fit and further authorize you to compromise, settle or otherwise receive and claim as you see fit, However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed, directly from me. I understand that whatever amounts you do not collect from insurance companies proceeds, whether it be all or part of what is due. I personally owe and agree to pay to you.
4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this State of Indiana.
5. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.
6. This Authorization for Assignment will be in continual effort until revoked by both parties.

________________ ______________________________
Date Patient/Insured Signature

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RECORDS RELEASE

To __________________, I hereby authorize you to release to ________________ any information including the diagnosis and records of treatment or examination rendered to me or all care during the period from __________________ to ________________.

________________ ______________________________
Date Patient/Insured Signature

________________ ______________________________
Date Authorized provider representative

CONSENT FOR TREATMENT OF MINOR

I being the parent, guardian or custodian of ____________________________________ A minor, the age of ________, do hereby authorize, request and direct Dr. Harris to perform in his judgment any necessary examination, x-ray, and chiropractic treatment for the condition.

________________ ______________________________
Date Parent, guardian, custodian

________________ ______________________________
Date Witness