PREFERRED CHIROPRACTIC
AUTHORIZATION & ASSIGNMENT FORM

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

You are hereby authorized to release any information you deem appropriate concerning my case to any insurance company, attorney, court or adjuster in order to process any claim for reimbursement of charges incurred for service rendered me by you.

Personal injury /Auto medical payment: I authorize direct payment to Preferred Chiropractic Center for all services I have received there. If a settlement should be reached in my case from any insurance company, court, attorney or adjuster, I authorize you to pay Preferred Chiropractic Center first; before any/all other professions involved with my case.

Ultimately, I agree to personally guarantee payment for all Chiropractic, Therapeutic & X-ray services I have received at Preferred Chiropractic Center. I understand that Chiropractic Adjustments are $65.00 per treatment, X-rays are $50.00 each and Therapies are $35.00 each. I realize that Dr. Stephen G. Prefer DC is a participating provider for Aetna & Cigna insurance companies only.

I understand that verification of my insurance benefits is a courtesy provided by Preferred Chiropractic in order to save me time. I agree not to hold Preferred Chiropractic or Dr. Stephen G. Prefer DC financially responsible in the event that inaccurate benefits information is ever provided by my health insurance carrier. I acknowledge and agree that this is a contract between Preferred Chiropractic Center and myself.

I understand that payment for Chiropractic services rendered me by you are due on the date of service. I realize that my health insurance benefits can not be verified after normal business hours, weekends or holidays. Let my signature below indicate that I agree to be personally responsible for payment and that I am financially prepared to pay today for all Chiropractic services I have received.

I authorize Dr. Stephen G. Prefer DC to turn my account over to a collection agency if my entire bill at Preferred Chiropractic is not paid within 30 days of my last treatment date. I realize that an additional two percent per month will be added to my bill after 30 days have elapsed. I fully understand that if my account should have to be turned over to a collection agency, it will be solely my responsibility to pay all collection agency fees in addition to my outstanding bill at Preferred Chiropractic. In the event that I fail to fully comply financially, I authorize Dr. Stephen G. Prefer DC to release the following information to a collection agency: my name, home and work addresses, social security number, phone numbers, billing history and treatment recognition signatures. Lastly, should a legal situation arise and judgment is awarded to Preferred Chiropractic, I agree to be personally responsible for all plaintiff & defendant fees regarding: court, attorneys, mediation, arbitration and or hearings. I realize that these professional fees are an additional expense that I have incurred and I understand that these expenses will be added to my bill at Preferred Chiropractic.

Patient Signature: ____ **Date** ____________

Print Name: ____