Brewer Chiropractic Clinic
702 IH 20W, Suite 100
Arlington, TX 76017
(817) 467-2010

Consent for Professional Services and Release of Information

I hereby authorize the Treating Doctor at Brewer Chiropractic Clinic, or whomever they may designate as their assistant to administer treatment, physical examination, X-ray studies, laboratory procedures, chiropractic care, or any clinic services that they deem necessary in my case or my minor child's case. I further authorize them to disclose all or any part of my or my minor child's medical record to any person or corporation which is or may be liable under a contract to the clinic, or to the patient, a family member or the employer of the patient for all or part of the clinic's charge, including, but not limited to hospital or medical service companies, insurance companies, workers' compensation carriers, welfare funds or the patient's employer. We at Brewer chiropractic Clinic value your privacy and will not release any information unless it has a direct outcome to your care.

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself = not between my insurance company and Brewer Chiropractic Clinic. I agree to pay my estimated portion at the time services are rendered (unless other arrangements have been made), including any deductibles. I further understand that the estimated portion is neither, a guarantee of payment by my insurance company, nor, necessarily an accurate reflection of my actual payment as determined by my insurance company upon processing my claims. I understand that I am responsible for all charges incurred by me at Brewer chiropractic Clinic regardless of insurance benefits. In the event that my insurance company does not pay on my charges at the estimated rate or within 60 days, I will immediately pay the balance owed on my account, unless other arrangements have been made in writing with Brewer Chiropractic Clinic.

***** For Women: I hereby certify that I am / am not pregnant. (Please circle one)*****

Signatures

If you understand and agree with all of the above, please sign below.

_____
Print Full Name

_____ _____
Patient Signature in Ink (Guardian Signature if patient is under age 18) Date

For your convenience, we will gladly file your insurance claims, but please be aware that you are ultimately responsible for payment for your care.