

**LOUISVILLE FAMILY CHIROPRACTIC**  
**Authorization, Assignment, Consent to Treat and Medical Release**

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

**MEDICAL RELEASE**

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.

**ASSIGNMENT OF BENEFITS**

I authorize the direct payment to you of any sum I now and hereafter owe you by my attorney out of proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

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 any such company (the pertinent data below) and authorize you to compromise, settle or otherwise resolve this claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company (or companies) contractually obligated, you will understand that whatever amounts you do not collect from insurance proceeds (whether it be part or all of what is due), I personally owe to you.

**AUTHORIZATION**

I, the undersigned, do hereby appoint Louisville Family Chiropractic, and any of its duly authorized agents, to serve as lawful attorney invested with all powers and authority necessary to endorse and cash any checks, drafts or money orders which are made payable to the undersigned above or as co-payee with Louisville Family Chiropractic when said payments are due for services rendered on behalf of the undersigned by the clinic.

**PREGNANCY RELEASE**

This is to certify that to the best of my knowledge I am not pregnant and that Louisville Family Chiropractic doctor(s) and his/her associates have my permission to perform an x-ray examination. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual period \_\_\_/\_\_\_/\_\_\_ (initial \_\_\_\_\_)

**CONSENT TO TREAT**

I, the undersigned, do hereby authorize Louisville Family Chiropractic, (and whomever may be designated as assistants) to administer such examinations, treatments and care, as they deem necessary.

A photocopy of this assignment shall be valid and have the same effect as the original

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Date

Patient's Signature

Witness Signature