Authorization For Exam, X-Rays, Treatment, And Release of Information

I, the undersigned, a patient of this office, hereby authorize Dr. Adam Akers, D.C. (and whoever assistants) to examine me. Examination may include x-rays, if indicated by the exam. X-rays have been proven to be harmful during pregnancy and for this reason if you are pregnant, you must tell us!

Pregnant? **Yes_____** **No_____**

Furthermore, I authorize Dr. Akers, D.C. to administer such treatment as is necessary, which may include Chiropractic Care and such additional therapy or procedures as are considered therapeutically necessary on the basis of findings during the treatment. I hereby certify that I have read and fully understand the above Authorization for Examination, X-Ray and Chiropractic Treatments, the reason why the above treatment is considered necessary, its advantages and possible complication, if any, and possible alternative modes of treatments, which were explained to me by Dr. Akers, D.C. or the examining doctor. I also certify that no guarantee or assurance has been made as to the results that may be obtained.

Assignment And Authorization

Akers Family Chiropractic, PSC
P.O. Box 1288
Pikeville, KY. 41502
Phone: 606-432-8395

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

1. I hereby attest to the accuracy of my medical and/or accident history and further certify that I present myself to Dr. Adam Akers Chiropractic Center for evaluation and/or treatment of a health-related condition and for no other purpose. I clearly understand that I am entirely responsible for payment should my insurance company deny payment.
2. I hereby irrevocably assign to you any right, title, interest, claim and/or assignment I may have against any insurance company obligated to make any type of payment for your charges, whether based on first party coverage or third-party coverage. I authorize and direct payment to you of any sum, which may become due under any contract of insurance covering your services.
3. Should any such insurance company fail to make payment, full payment, or prompt payment, of any claim, I hereby assign and transfer to you any cause of action that might exist in any favor against such insurance company, and you shall be substitute in full place instead of me as a Plaintiff in any litigation arising out of such cause of action. Any and all charges, fees and/or expenses incurred from any payment/collection will be charged to the insurance company.
4. I understand that you will make all reasonable efforts to collect any insurance benefits under any such policies before you proceed with any attempts to collect sums not paid by the insurance company from me.
5. You are authorized to release and request any information you deem appropriate concerning my physical condition or treatment to or from any insurance company, attorney, adjust or doctor. This may be done in order to process any claim for reimbursement for any charges incurred by me or any services rendered.
6. A photostatic copy of this authorization shall be considered as effective and valid as the original.

DATE:_____ **SIGNED:**_____