



HURLEY
chiropractic

Patient Authorization

Patient Name _____

Social Security Number _____

Date of Birth _____

AGREEMENT TO ACCEPT CARE

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me can be immediately due and payable.

I hereby authorize the Doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for x-rays is for examination only and the x-ray negatives will remain property of this office, being on file where they may be seen at any time while I am an active patient in this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. Patient may obtain copies of their file and x-rays upon request. Copying fees may apply.

X _____
Patient signature or authorized person acting on patient's behalf _____ Date _____

AUTHORIZATION AND ASSIGNMENT

In consideration of you providing 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.
1. 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 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.
2. 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 data) and authorize you to prosecute said action either in my name as you see fit and further authorize you to have been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from insurance companies proceeds, whether it be all or part of what is due, I personally owe you.
3. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this state/province of Arkansas.
4. I further agree that this Authorization and Assignment is irrevocable until all monies owed Hurley Chiropractic Clinic are paid in full.

X _____
Patient signature or authorized person acting on patient's behalf _____ Date _____

RECORDS RELEASE

I hereby authorize you to release to Hurley Chiropractic any information including the diagnosis and records of any examination or treatment rendered to me previously at your facility. Furthermore at the request of Dr. Hurley's office please provide the actual films in the case of x-ray and MRI.

X _____ Date _____
Signature of Patient

Hurley Chiropractic Clinic
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Conway, AR 72032
501-513-3322 fax 501-513-3065