GINGELL CHIROPRACTIC CENTER, P.C.
9450 S. Main Street, Suite 106 • Plymouth, MI 48170
734/453-2447

CHIROPRACTIC AUTHORIZATION & EXPLANATION

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

A. I Authorize Release of Any Medical Information Necessary to Process this Claim and Request Payment of Insurance Benefits Either to Myself or the Party Who Accepts Assignment Below.

DATE________________ SIGNATURE________________________________

B. I Authorize Payment of Any Medical Benefits from________________________ to be Paid Directly to Gingell Chiropractic Center, P.C. for any Service Rendered to Me.

DATE________________ SIGNATURE________________________________

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to 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.

2. 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.

3. I understand that whatever amounts you do not collect from insurance companies proceeds, whether it be all or part of what is due, I personally owe you.

4. I hereby waive the statute of limitation on collection regarding my case and care.

DATE________________ SIGNATURE________________________________

"Serving the Community for Over 30 Years"

DR. GREGORY J. GINGELL