

## RELEASE OF INFORMATION

### ASSIGNMENT OF BENEFITS

I hereby assign all medical and health care benefits, to include major medical benefits to which I am entitled including Medicare, auto insurance, private health insurance, and any other plans to Rethwisch Family Chiropractic, P.C. A copy or fax of this assignment is to be considered as effective and valid as the original. I understand that I am financially responsible for all charges whether paid by insurance or not. I hereby authorize the release of any information necessary to secure payment. I certify that I have read and understand the above assignment of benefits.

### AUTHORIZATION TO TREAT

I, the undersigned, hereby authorize Rethwisch Family Chiropractic, P.C., and any designated employees or interns to perform diagnostic procedures and render treatment. Diagnostic procedures include any procedures that may aide the doctors to form a diagnosis, evaluation, and treatment plan, and may include but not be limited to physical, neurological, orthopedic, laboratory and radiological examination. Treatment includes but is not limited to joint manipulation, physiotherapies, and any supportive measures within the scope of practice of the doctors and their employees.

I hereby certify that I read and understand the authorization to treat and am aware of treatment advantages, as well as complications, if any, alternative forms of treatment, and that no guarantee has been made.

### AUTHORIZATION FOR NONCOVERED SERVICES

Some insurance plans may not cover all or your visits, or all of your procedures. I hereby authorize treatment for non-covered services and understand that I am financially responsible for any costs not covered by insurance.

### *\*CONSENT TO TREATMENT OF A MINOR CHLD\**

*I hereby authorize Rethwisch Family Chiropractic, P.C. and designated employees and interns to diagnose and treat as described above, my son, daughter, or dependent:*

\_\_\_\_\_ *(minor's name). I hereby certify that I am the parent or legal guardian of the above named minor.*

## RELEASE OF INFORMATION

I hereby authorize the release or any and all of my medial records to Dr. Jeremiah Rethwisch, or a representative thereof. Please Fax records to: (402) 408-6620.

I hereby authorize Dr. Jeremiah Rethwisch to release any and all medical records pertaining to my treatment to other health care professionals or attorneys as needed. A copy or fax of this authorization shall be considered as effective and valid as the original. It shall remain effective until I revoke it with written authorization. I hereby certify that I have read and understand the above release of information.

NAME: \_\_\_\_\_ DOB: \_\_/\_\_/\_\_\_\_

SIGNED \_\_\_\_\_ DATE \_\_/\_\_/\_\_\_\_