PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

A. I authorize release of any of my medical information necessary to process my claims.

SIGNATURE_____ **DATE** _____

B. I authorize payment of any medical / chiropractic benefits to be paid directly to the provider for any services rendered to me.

SIGNATURE_____ **DATE** _____

C. I, the undersigned certify that I (or my dependant) have insurance coverage and assign directly to this clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. My insurance company and I have a contract, this contract is not between Dr. Zebrasky and the insurance carrier rather is between myself and the company. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I will be responsible to pay the charges personally in the event the insurance company fails to pay for services within 90 days from the time of submission. I assume the responsibility of obtaining a referral, preauthorization or any and all other insurance imposed requirements for treatment.

SIGNATURE_____**DATE** _____

D. Medicare/Medicaid Patients: I certify that the information provided by myself or representative in applying for Medicare/Medicaid payment is correct and I authorize release of any information necessary to determine my eligibility under Medicare/Medicaid, I hereby request and assign payment of Medicare/Medicaid benefits to Dr. Christian Zebrasky DC. I understand that I am responsible for deductibles, co-payments, co-insurance and any expenses or charges not covered by government payers.

SIGNATURE_____**DATE** _____