

LAURIE A. KELLEHER, D.C., P.C.

Please read, sign and date each of the following:

Release of Records

I do hereby authorize Laurie Kelleher, DC to release my medical and billing records to any of its billing companies, attorneys, adjusters, etc. for the purpose of getting my bill paid.

Signature

Date

Consent to Treat

I hereby authorize Laurie Kelleher, DC and her assistants to perform medical examination, physical therapy, spinal manipulation, and/or diagnostic testing to me today.

Signature

Date

Financial Agreement

I have been advised by Laurie Kelleher, DC that my co-payment or co-insurance will be collected on each visit. I also understand that if I am not able to afford my entire co-payment or co-insurance, special arrangements may be made for me. However, it is my responsibility to notify Laurie Kelleher, DC of my situation.

Signature

Date

Assignment of Benefits

I understand that my insurance company may not accept assignment. I understand that my insurance company will pay me directly for the services rendered to me from Laurie Kelleher, DC. I also understand that I will receive check(s) from the Insurance company made payable to my name, to me directly. I also understand that it is my responsibility to forward these checks and Explanation of Benefits to Laurie Kelleher, DC immediately upon receipt. I understand that it is illegal for me to cash or deposit these check(s) that I receive for services from this provider particularly when I have not paid for the services personally. I understand that if I fail to forward the check(s) for these services, it will be my responsibility to pay my balance in full for all services provided to me. I know that I will be given five business days to settle my account before legal proceedings begin. If my account is not settled I will also be responsible for any additional costs, such as court cost and legal fees. I understand that services provided to me today may be issued on more than one check and I agree to forward ALL checks regarding any treatment to Laurie Kelleher, DC. I willingly sign this agreement.

Signature

Date

Limited Power of Attorney

I expressly authorize and give power of attorney to Laurie Kelleher, DC and her billing agents for the signing and completing of any form in the completion of my claims and endorsing any check made payable to me, in support of processing or making payment of a claim for any charges incurred by me at this office. Further, this office acknowledges that it is only entitled to receive payment for those charges which were incurred through this office and any overpayment will be refunded appropriately and timely.

Signature

Date