1. **AGREEMENT FOR ALTERNATIVE TREATMENTS**

I understand and agree my doctor may send me to another health provider for evaluation or modalities if he feels it will be in my best medical interests.

1. **INSURANCE COMPANY - ASSIGNMENT OF BENEFITS AND AUTHORIZATION.**

I hereby authorize my doctor to release any information acquired in the course of my treatment or examination to any insurance company with which I wish to file a claim.

I hereby authorize payment directly to my doctor for any and all treatment I receive while under his/her care. I understand that I am fully responsible for any balance in which my insurance does not pay. I agree to make any payment on my account within thirty (30) days and I understand if payment is not made in sixty (60) days, my account will be turned over to our collection agency. **\*\*\* I understand that if I miss an appointment or do not cancel at least 24 hours in advance, I will be billed $50.00 for that reserved time. \*\*\***

1. **WORKERS’ COMPENSATION RELEASE AND AUTHORIZATION**

I have reported this injury to my respective employer and an accident report has been filed. I understand a copy of each examination report will be sent to my compensation carrier and/or my attorney representing my case in the event that I retain one. If the claim has been reported, I understand that should my claim be denied, I will be responsible for all medical bills incurred.

1. **MEDICAL FORMS**

I understand that the necessary forms to file any private insurance such as any disability forms for which I might be eligible for, are subject to a $40.00 filing fee that is payable in advance.

Your signature below is only acknowledgement that you have read and acknowledged these notices. This document will be placed in your medical chart.

Printed Name:

Signature:

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_