

Name: \_\_\_\_\_

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

Please read, sign and date each of the following:

**Release of Records**

I, do, hereby authorize Sarasota Chiropractic to release my medical and billing records to any of it's billing companies, attorney(ies), adjusters, etc, solely for the purpose of getting my bill paid. I understand that all records released will be handled in compliance of the patient privacy act.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Consent to Treat**

I, hereby, authorize the doctors and staff of Sarasota Chiropractic located at 3436 Bee Ridge Road, Sarasota, Florida 34239, to treat me with examination, spinal manipulation, diagnostic testing, therapeutic modalities, and any other service that is needed in my plan of treatment in order to treat my condition. As with any health care procedure, there is an inherent risk, and I acknowledge that no guarantees have been made to me as a result of any treatment or examination in the office. Equally, there are risks to remaining untreated such as formation of adhesions and reduced mobility which may set up pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Cancellation Agreement**

I, hereby, agree to provide 24 hours cancellation notice for my scheduled neuromuscular therapy appointments. If I habitually fail to keep my appointments (more than 3 times), with one of the licensed massage therapists, I will be billed and responsible for a \$30.00 no show fee.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Records Release**

To \_\_\_\_\_, I hereby authorize you to release to \_\_\_\_\_ any Information including the diagnosis and records of treatment or examination rendered to me for all care during the period from \_\_\_\_\_ to \_\_\_\_\_.

Date \_\_\_\_\_

Patient/Insured Signature \_\_\_\_\_

Date \_\_\_\_\_

Staff Signature \_\_\_\_\_

**Limited Power of Attorney**

I expressly authorize and give power of attorney to Sarasota Chiropractic and their 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 claim for any charges incurred by me at these offices. Further, these offices acknowledge that it is only entitled to receive payment for only those charges which were incurred through their office and any overpayment will be refunded appropriately and timely.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date