

**ASSIGNMENT OF RELEASE- SIGNATURE ON FILE**

I authorize Iowa Chiropractic Clinic, P.C. to sign future claims in their office for myself. I have been informed that this signature will remain on file until I request it withdrawn. I have also been informed that I have the right to withdraw my name from the signature file agreement at anytime when I notify Iowa Chiropractic Clinic, P.C. in writing.

I authorize direct payment to Iowa Chiropractic, P.C. of any sum I now or hereafter owe, by my attorney out of the proceeds of any settlement in any case, and by any insurance company obligated to make payment to me or you based on the whole or part upon charges made for your services. I understand that I am financially responsible for all non-covered charges. I also authorize the release of my records from Iowa Chiropractic Clinic, P.C. to the insurance company to help secure payment of services.

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

Insurance Company \_\_\_\_\_

**INFORMED CONSENT FOR CHIROPRACTIC CARE**

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or healthcare if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures whatever he is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician provides a specialized, non-duplicated healthcare service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your healthcare regime.

I understand that if I am accepted as a patient by Iowa Chiropractic Clinic, P.C., I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_