SPRING CHIROPRACTIC

Signature on File

- I authorize use of this form on all my insurance submissions.
- I authorize release of information to all my insurance companies.
- I understand that I am responsible for all co-pays or deductibles.
- I authorize my healthcare provider to act as my agent in helping me obtain payment from my insurance companies.
- I authorize direct payment for services rendered to Spring Chiropractic.
- I permit a copy of this authorization to be used in place of the original.

Name (Please Print) ____

Signature ____

Date ____________________