



ASSIGNMENT OF BENEFITS

I authorize and direct that payment be made directly to:

Hatch Chiropractic & Wellness
10841 S. Crossroads Drive, Suite 17
Parker, CO 80134

for any and all insurance benefits or reimbursement for services rendered which amounts would otherwise be payable to me under any insurance or pre-paid healthcare plan.

Date

Patient/Legal Guardian Signature

AUTHORIZATION AND CONSENT

I authorize the release of any information concerning my health and health care services to my insurance companies, pre-paid health plan or Medicare.

If at any time you want to revoke this consent it must be done in writing.

Date

Patient/Legal Guardian Signature

PAYMENT AGREEMENT

I understand that there is no guarantee that my insurance companies or pre-paid health plan will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges.

Date

Patient/Legal Guardian Signature