Authorizations and Releases *(* = Required Signature/date)*

PRINT NAME_____**File #**_____

Consent for Treatment

I, the undersigned, hereby authorize Dr. Rubino and whomever he may designate as his assistant(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as necessary.
I, also, certify that no guarantee or assurance has been made to the results that may be obtained.
I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that my amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. **HOWEVER, I CLEARLY UNDERSTAND THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME OR DIRECTLY TO MY INSURANCE COMPANY, WHICHEVER IS APPLICABLE, AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT, IF APPLICABLE.**

*Patient's Signature_____Date_____/_____, 2020

Authorization to Release Medical Information

I authorize Dr. Rubino to release any medical information pertinent to my treatment plan to an authorized representative for review. This authorization for release of information shall remain valid for the term of my coverage under my current policy. I certify that all insurance information given to this clinic is correct and complete. I also know that I am entitled to receive a copy of this authorization form.

*Patient's Signature_____ Date_____/_____, 2020

Request For Payment of Benefits To Provider of Care *

I hereby authorize the _____ Insurance company/ Insurance Administrator to pay by check, and for it to be mailed directly to Dr. Rubino the expense benefits allowable to me under my current policy, as payment toward the total charge for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

*Patient's Signature_____ Date_____/_____, 2020

Attorney Representation and Protection of Balance (if applicable)

I, the undersigned patient am directing my attorney, _____, to pay any outstanding bills out of my settlement and, in effect, protecting any such balance. I hereby make and declare the instructions herein contained to be irrevocable. I fully understand that I am directly responsible for all medical bills and that this agreement is made solely for the doctor's additional protection and consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but will require me to make payment on a current status.

Patient's Signature_____ Date_____/_____, 2020

Consent For Treatment of Minor (if applicable)

I hereby authorize Dr. Rubino and whomever he may designate as his assistant(s) to perform diagnostic test, including but not limited to radiographs, and to administer treatment as he deems necessary to my _____ (child's name)_____.
(child's relationship)
Parent's or Guardian's Signature_____ Date_____/_____, 2020
(Circle one that applies)

X-Ray/Medical Records Release *

I have requested the release of records of _____that are part of the records at Michelangelo A. Rubino's Chiropractic office. I hereby request and authorize you, your employees and agents to furnish to the person(s) listed below or anyone designated in writing by them, all copies of records and reports, including copies of x-rays and photostatic copies, abstracts or excerpts of all records and any other information they may request relating to any examination, treatment or opinion concerning any condition that I may have had in the past, now have, or may have in the future. Please forward this to:

*Patient's Signature_____ Date_____/_____, 2020