AUTHORIZATIONS AND RELEASES

NAME_________________________________ ID#___________________________

CONSENT FOR TREATMENT

I, the undersigned, hereby authorize Dr. G. Scott Birnie, D.C. and/or Dr. Nate Lynott, D.C. and whomever he may designate as his assistant(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as is 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 on making collection from the insurance company and that any 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 AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

Patient's Signature____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete

Patient's Signature____

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. G. Scott Birnie, D.C. and/or Dr. Nate Lynott, D.C., the expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges 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 and any and all drafts for payment of my bill.

Patient's Signature____

ATTORNEY REPRESENTATION AND PROTECTION OF BALANCE

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 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____

CONSENT FOR TREATMENT OF MINOR

I hereby authorize Dr. G. Scott Birnie, D.C. and/or Dr. Nate Lynott, D.C. and whomever he may designate as his assistant(s), to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as he deems necessary to my child, ______________________________.

Guardian's Signature______________________________

X-RAY/MEDICAL RECORDS RELEASE

I, ______________________, have requested the release of records which are a part of the records at (facility) ______________________________.

I hereby request and authorize you, your employees and agents to furnish to the person 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 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: Dr. G. Scott Birnie, D.C. or Dr. Nate Lynott, D.C., 5512 Britton Drive, Suite 100, Long Beach, CA 90815 Telephone (562)594-6644, Fax (562)594-6114

Patient's Signature______________________________

Date ______________________