Total Body Chiropractic

Patient's Name **Contract Number**

AUTHORIZATION TO RELEASE INFORMATION

I authorize the doctor and his staff named below to release any information deemed appropriate concerning my physical condition and treatment to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered and hereby release him/her of any consequences thereof. I agree that a photo static copy of this agreement shall serve as the original.

Signature Date

AUTHORIZATION TO PAY DOCTOR/CLINIC

I hereby authorize and direct payment of any medical expense benefits allowable to the doctor/clinic named below as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the doctor/clinic. I agree that a photo static copy of this agreement shall serve as the original.

Signature Date

Authorization to Pay / Release Authorization
is granted to
Total Body Chiropractic
613 Potomac Place, Suite 202
Smyrna, TN 37167

Physician Tax ID 26-3797524