INSURANCE INFORMATION

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account on receipt. 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. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize the doctor and whomever he may designate as his assistants to administer treatment, physical examination, x-ray studies, lab procedures, chiropractic care or any clinic services that he/she deems necessary in my case. I further authorize him/her to disclose all or any part of my {patient's) records to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

MY RESPONSIBILITY FOR PAYMENT OF FEES

I fully understand and agree that I am directly and fully responsible to pay this clinic, in full, for all professional services and/or products provided to myself and members of my family. I further understand and agree that such payment to this clinic is not contingent on any settlement, claim, judgement or verdict by which I may eventually recover said fee. I also agree to pay all reasonable costs of collection, attorney fees and interest at the ANNUAL PERCENTAGE RATE of 21% (1.75% PER MONTH) on any PAST DUE BALANCE (over 60 days old).

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

To: (Provider) ___________________________ Phone: (   ) _______________ Fax (   ) _____________

I, __________________________________ request the following information:
(Patient's name)

(   ) X Ray   (   ) History   (   ) Records   (   ) Diagnosis   (   ) Treatment   (   ) Reports   (   ) Billings

concerning my: (   ) Accident   (   ) Injury   (   ) Other ____________________________________

To be sent to:

For Purpose of:

____
(Specify)

According to the Health and Safety Code, these records must be provided within 15 days of receipt of this notice.

___________________________________ have read and fully understand the above statements.
(Print Name)

XX ____________________________________   ___________________________
(Signature)   (Date)

I, __________________________________ being the parent or legal guardian of ______________________________ have read and fully understand the above terms of acceptance and hereby and hereby grant permission for my child to receive chiropractic care.

AIM HIGH CHIROPRACTIC, PC CLINICS:

945 S Federal Blvd., #B
Denver, CO 80219
303-922-8146

50 S Federal Blvd.
Denver, CO 80219
303-922-2977

1350 Chambers Rd, Ste103
Aurora, CO 80011
303-577-2040

7200 W 44th Ave
Wheat Ridge, CO 80033
303-423-1925

331 14th St., #208
Denver, CO 80202
720-956-0156