WEST END CHIROPRACTIC
& REHAB CENTER

WEST END CHIROPRACTIC & REHABILITATION
4255 Laclede Ave.
St. Louis, MO 63108
Telephone: (314) 361-4650
Fax: (314) 361-4663

PATIENT AUTHORIZATIONS AND PAYMENT AGREEMENTS

Patient Name: _____ Case Number: _____

ASSIGNMENT OF BENEFITS

I authorize and direct payments to be made directly to:

West End Chiropractic & Rehabilitation Center
Michael L. Gerdine, D.C.
4255 Laclede Ave.
St. Louis, MO 63108
Ph: (314) 361-4650 Fax: (314) 361-4663

For any and all insurance benefits or reimbursement for services rendered by Michael L. Gerdine, D.C. which amounts would otherwise be payable to me under any insurance or pre-paid health care plan.

Patient Signature_____ Date: _____

RELEASE OF MEDICAL INFORMATION

I authorize the release of any information concerning my health care series to my insurance companies or pre-paid health plan should they request it.

Patient Signature: _____ Date: _____

OFFICE PAYMENT AGREEMENT

I hereby accept full responsibility for payment of services rendered to me. I understand that the health insurance is an arrangement between my insurance company and me. I further agree to be personally responsible for payment or charges not covered by my insurance policy (ies) and I understand that in the event it becomes necessary to employ an attorney to collect any outstanding monies due, I will be responsible for all fees incurred by Dr. Michael L. Gerdine.

Patient Signature: _____ Date: _____