



CLYNE CHIROPRACTIC & WELLNESS, LLC.

- 1. I HEREBY AUTHORIZE CLYNE CHIROPRACTIC & WELLNESS, LLC TO RECEIVE ANY INFORMATION WHICH MAY HAVE BEEN ACQUIRED BY EXAMINATION OR OTHER MEANS OF MY PHYSICAL CONDITION, AND I HEREBY RELEASE THEM OF ANY CONSEQUENCES THEREOF.**
- 2. I ACKNOWLEDGE THAT I HAVE RECEIVED AND OR READ THE PRIVACY STATEMENT ACKNOWLEDGEMENT OF CLYNE CHIROPRACTIC & WELLNESS, LLC.**
- 3. I HEREBY AUTHORIZE RELEASE OF INFORMATION NECESSARY TO FILE A CLAIM WITH MY INSURANCE COMPANY.**

DATE _____/_____/_____ _____
PATIENT'S SIGNATURE

- 4. PATIENT IS SOLELY RESPONSIBLE FOR ANY OUTSTANDING BALANCES DUE TO CLYNE CHIROPRACTIC & WELLNESS, LLC UPON COMPLETION OF THEIR TREATMENT.**
- 5. I ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO CLYNE CHIROPRACTIC & WELLNESS, LLC.**

DATE _____/_____/_____ _____
PATIENT'S SIGNATURE