Aurora Central Chiropractic
2295 S. Chambers Road
Aurora, CO 80014
303-696-6691

**RECORDS RELEASE AND PAYMENT AGREEMENT**

For value received, I hereby assign to Dr. Rhonda Jackson, DC (hereinafter referred to as the Doctor) the total amount of my bill for all health care services provided by the Doctor.

In the event of checks written by me where they are returned due to non-sufficient funds, closed accounts or any other reason, I am still responsible for this debt to the Doctor plus an additional $20.00 service charge. The above agreement also applies to credit cards.

I hereby direct payment be made directly to the Doctor. I hereby appoint the Doctor to ask, demand, sue for and collect for all health care service provided to me.

I hereby authorize the Doctor to release and to permit the examination or copying of any of my medical records, x-rays, laboratory reports and the results of all tests of any type or character to such persons as the Doctor deem appropriate.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that without current insurance information, including and up-to-date insurance card, Aurora Central Chiropractic may not be able to process my claim. I understand that it is my responsibility to inform Aurora Central Chiropractic of any changes in my insurance coverage, address, and phone in a timely manner. Therefore, I accept full responsibility for cash payment today if my insurance information is or was inadequate to bill appropriately. I also understand that Aurora Central Chiropractic is not responsible to know the details of my insurance policy. I accept full responsibility for items that are not an insurance benefit. I understand that I have the right to refuse treatment until I can verify my benefits.

Furthermore, I understand that the Doctor's 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 the Doctor's 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, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition, as he/she deems appropriate through use of manipulation throughout my spine. It is understood and agreed the amount paid the Doctor is for examination, treatment and x-rays only. The x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Dr. Rhonda D. Jackson, D. C. and/or Aurora Central Chiropractic is entitled to see all settlement benefits.

PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE WITH THIS OFFICE. YOU AGREE THAT IF IT BECOMES NECESSARY TO FORWARD YOUR ACCOUNT TO OUR COLLECTION AGENCY, IN ADDITION TO THE AMOUNT OWED, YOU WILL ALSO BE RESPONSIBLE FOR THE FEE CHARGED TO US BY THE COLLECTION AGENCY FOR COSTS OF COLLECTIONS AND REASONABLE ATTORNEY FEES, ALONG WITH ANY ADDITIONAL COURT COSTS AWARDED BY THE COURT.

Patient Signature _____ Date _____

Guardian or Signature
Of Authorizing Care _____ Date _____