

**Total Health Concepts
Minicucci Chiropractic, P.C.**

RECORDS RELEASE: *I hereby authorize the release of any information, including medical and billing information by Total Health Concepts to my referring doctor/primary care physician, insurance company, the responsible party named above, and immediate family on behalf of myself and/ or dependents.*

Date ___/___/___ Signed: _____

ASSIGNMENT OF BENEFITS: *I hereby authorize payment of Chiropractic benefits to Total Health Concepts for services rendered to me and/ or dependents.*

Date ___/___/___ Signed: _____

FINANCIAL STATEMENT: *All clinic services and supplies may not be covered under my insurance plan. I understand that any **NON-COVERED SERVICES/ SUPPLIES** will be my responsibility. I agree to pay any collection costs, including but not limited to, filing and attorney's fees, if necessary. I agree to pay a one and one quarter percent per month (fifteen percent annual) finance charge for balances over sixty days. **I WILL BE CHARGED FROR APPOINTMENTS CANCELLED OR BROKEN WITHOUT 24 HOURS ADVANCE NOTICE.***

Date ___/___/___ Signed: _____

TREATMENT OF MINOR CHILD: *I hereby authorize Dr. Kelly Minicucci to provide chiropractic treatment for my child.*

Date ___/___/___ Signed: _____