820 Chuck Gray Court
Owensboro, Kentucky 42303
(270) 685-5100 Office
(270) 683-3100 Fax

Jeffry T. Stallings, D.C.
Kara Liebenauer, D.C.

Brett G. Stallings, D.C.
W. Blake Main, D.C.

**Authorization to Release Information**

By signing below, I authorize Stallings Chiropractic Center to release information concerning my condition to any insurance company, attorney or adjuster.

**Privacy Consent**

I consent to use and disclosure of protect health information for treatment, payment and health care operations. I have the right to revoke this consent in writing, except where Stallings Chiropractic Center has already made disclosures in reliance on my prior consent.

**Patient Data Form**

After reading and filling out the Patient Data form, my signature will verify that all the information I have given Stallings Chiropractic Center is accurate. Every health care profession including chiropractic has potentially serious risks associated with diagnostic and treatment procedures. If I have any questions at all or are concerned in any way about these risks, I will ask. Stallings Chiropractic Center has information and consultations at no charge regarding any risks inherent with their diagnostic and treatment procedures. By signing the Patient Data form, I agree that I have read and understood the above statement.

**Financial Responsibility**

I acknowledge full financial responsibility for services rendered by Stallings Chiropractic Center. I understand that I am responsible for prompt payment of any amounts due including, but not limited to, co-pays, deductibles and coinsurance amounts. **I understand that payment of co-pays, deductibles and coinsurance amounts are expected at time of service, as well as any prior balance I may owe.** Stallings Chiropractic Center reserves the right to refuse treatment based on outstanding balances. I also consent that direct payment may be made on my behalf to Stallings Chiropractic Center for any care and imaging furnished. I agree to be responsible for all reasonable attorney fees and collections costs in the event of default of payment of my charges. If my insurance (private insurance, Medicare, Workers' Compensation and Personal Injury) does not pay for any reason, payment will become my responsibility.

**Radiology Services**

I understand that my treating doctor may have a radiologist at OHRH review my radiologic images. Radiology services are billed separately by OHRH.

Signature: ______________________________ Date: ________________