Schmit Chiropractic Offices, LLC
Dr. Ed Schmit **Dr. Shaun Roberts**
207 W. Main St. • Portland, IN 47371 • (260) 726-9661 • Fax (260) 726-8734

Primary Insurance _____
Policyholder _____ Employer _____
Birthdate of policyholder _____ Relationship of policyholder _____
Address of policyholder _____
ID# _____ Group # _____

Secondary Insurance _____
Policyholder _____ Employer _____
Birthdate of policyholder _____ Relationship of policyholder _____
Address of policyholder _____
ID# _____ Group # _____

I HEREBY AUTHORIZE SCHMIT CHIROPRACTIC OFFICE, LLC TO RELEASE ANY INFORMATION CONCERNING MY EXAMINATION OR TREATMENT.

_____ _____
(patient's signature) (date)
(parent's signature, if patient is a minor)

** IF YOU HAVE INSURANCE COVERAGE AND OUR OFFICE WILL BE COLLECTING ** MONEY FROM THIS COMPANY FOR PAYMENT OF YOUR CHARGES IN OUR OFFICE, THE FOLLOWING SECTION MUST BE READ AND SIGNED.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance 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 me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable.

I HEREBY ASSIGN PAYMENT DIRECTLY TO SCHMIT CHIROPRACTIC OFFICES, LLC FOR PROFESSIONAL SERVICES RENDERED AND I SHALL BE PERSONALLY RESPONSIBLE FOR ANY UNPAID BALANCE TO THE DOCTOR.

_____ _____
(insured's signature) (date)