MILLER CHIROPRACTIC WELLNESS CENTER
4446 MAIN ST., SUITE 100
SNYDER, NY 14226
(716)204-0743
FAX: (716)204-0747
E-MAIL: drmiller@miller-chiro.com

RECORDS RELEASE

TO:_____

I hereby authorize you to release to MILLER CHIROPRACTIC WELLNESS CENTER any information including the diagnosis and records or any testing, treatment or examination rendered to me during my period of treatment.

Authorized Person s Signature:_____ Date:_____

PAYMENT AUTHORIZATION

I authorize payment of any medical benefits to be paid directly to MILLER CHIROPRACTIC WELLNESS CENTER for any services rendered to me.

Authorized Person s Signature:_____ Date:_____

TERMINATION OF CARE WAIVER

I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my attending doctor at this chiropractic office, he has full and complete right to suspend my case with my insurance carrier and relinquish any disability granted me within a reasonable period of time.

Authorized Person s Signature:_____ Date:_____

CONSENT OF TREATMENT OF A MINOR

I hereby authorize Dr. David S. Miller to administer chiropractic care as he deems necessary for:
_____(name of child) who is my _____(indicate relationship to child).

City and State where this was signed: Snyder, New York

Authorized Person s Signature:_____ Date:_____

Witness Signature:_____ Date:_____

MARKETING WAIVER

I hereby consent that Miller Chiropractic Wellness Center is able to use my name and/or statements for any newsletters, brochures, flyers, or other marketing promotions as they deem appropriate.

Authorized Person s Signature:_____ Date:_____