

Dr. Richard Picard

Signature On File

- I authorize the release of records requested by my insurance company acquired in the course of my examination and treatment
- If involved in a personal injury such as a car accident I authorize the release of records to the insurance companies that request my records
- I authorize the release of records and reports to my medical doctor
- I authorize the use of this signature on all insurance forms
- I authorize and direct my insurance benefits to be paid directly to the doctor
- I authorize my doctor to act as my agent in helping me obtain payment from my insurance
- I am financially responsible my co-payments, deductibles and non-covered services
- I am financially responsible for any office visits my insurance company denies
- I hereby give my permission to the doctor to administer treatment and perform procedures, as he may deem necessary in the diagnosis and treatment of my condition.
- I understand that just as there is a risk in all medical procedures, although rare; cervical spine manipulation can cause vertebral artery injury (stroke) in 1/500,000 cases.

By signing below I have read and agree to the above statements.

Print Name: _____

Signature: _____ Date: _____