AUTHORIZATION & ASSIGNMENT

In consideration of Dr. Peter May undertaking to treat me, I agree to the following:

RELEASE

I authorize my insurance company, attorney or any other holder of medical or billing information about me to release directly to Dr. Peter May any information needed to determine my insurance benefits or the benefits payable for services provided by Dr. May.

I authorize all medical personnel to provide medical history information, examination and test results as it may relate to my care with Dr. May.

I authorize Dr. May to release all medical PHI and billing information as necessary, as it pertains to my care in his office, to attorneys, my other treating physicians, diagnostic facilities and/or insurance companies or their representatives, including: utilization review companies.

ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare and/or other Private Insurance benefits or proceeds from any legal claim relevant to treatment in this office, as secured by an Attorney, be paid directly to Peter D. May, DC for any/all services provided by him, as my chiropractor, to me. If not possible, and the check is made in my name, I request that the check be mailed directly to Dr. May and, furthermore, I authorize Dr. May to cash the check in my name as payment on my account.

I acknowledge that my insurance may not cover all or part of the services of health products (orthotics, supplements, missed appointments, etc) provided and that I am financially responsible to Peter D. May, DC for all charges incurred, to the extent allowed by law. Should the need arise, I authorize Dr. May to file a complaint with the Insurance Commissioner on my behalf.

Signed: ____ Dated: __________

Witnessed: ____

PRIVACY NOTICE

I acknowledge that I have received a copy of the Practice's Privacy Notice that has an effective date of April 14, 2003.

Print Name: _____________________________ Signed : _____________________________ Dated: _______

I authorize Dr. May to contact and release my name to:

___My emergency contact: _____________________________

___ The person who referred me to this office: _____________________________

___ My immediate family: _____________________________ other: _____________________________

___Office newsletter