



### Patient Authorization Form

I have had the **Notice of Privacy Practice** made available to me and have had the opportunity to review its contents prior to signing this authorization.

I authorize the use of my medical information according to the **Notice of Privacy Practice**.

I authorize the release of any medical information necessary to process my claim.

I authorize the following individual(s) (family, spouse, friends) access to information about my medical records and appointments at **Whitaker Wellness / Powell Valley Wellness**:

**Name(s):** \_\_\_\_\_

I authorize **Whitaker Wellness / Powell Valley Wellness** to send text message reminders about my appointments and to leave a message whenever they need additional information from me.

- Check box if you want to **OPT OUT** of voicemails.
- Check box if you want to **OPT OUT** of text message reminders.
- Check box if you want to **OPT OUT** of Email reminders.

I authorize payment of medical benefits to **Whitaker Wellness / Powell Valley Wellness**

I authorize the release of information to any other entity for which I have signed a release.

I authorize **Whitaker Wellness / Powell Valley Wellness** to release information to any entity that I personally instruct them to release information to.

We, at **Whitaker Wellness / Powell Valley Wellness**, will gladly bill your insurance company. However, the full responsibility for payment of all professional services belongs to you, the patient.

If you do not have insurance or choose not to use your insurance, we do offer a Time Of Service Discount (TOSD) here. The TOSD will give you set pricing on your treatments here. You can use the TOSD for chiropractic, massage, and/or primary care. Pricing is dependent on the services performed. Please ask the front desk for specific pricing. **In order to qualify for the TOSD you have pay for your services the day of visit. If you do not pay the same day you were seen then you do not qualify for the TOSD and must pay full pricing.**

\_\_\_\_\_  
**Patient Name**

\_\_\_\_\_  
Date

\_\_\_\_\_  
**Patient Signature** (Parent Signature if minor)

\_\_\_\_\_  
Parent Name (If Minor)