

Stover Sports Injury & Chiropractic Wellness
327 Dahlonga Street, Suite 1801-B
Cumming, GA 30040

Phone: 678-513-1450
Fax: 678-513-6120

SIGNATURE ON FILE

Please check in each box stating that you understand the below statements.

- I authorize use of this form on all of my insurance submissions.
- I authorize release of information to all of my Insurance Companies.
- I understand that I am responsible for my bill. Any check payment dishonored by your bank will result in a \$30 returned check charge being added to your account.
- I authorize my doctor to act as my agent in helping me obtain payment from my Insurance Companies.
- I authorize payment direct to my doctor.
- I permit a copy of this authorization to be used in place of the original.
- I understand that if I miss a scheduled appointment without 24-hour notice of cancellation, I will be charged a NO-SHOW fee of \$25.
- I authorize Stover Chiropractic to send monthly information to my e-mail address which is listed below.

.....@.....com

Name: (Please Print) _____

Signature: _____

Date: _____