



**Genesis
Chiropractic**

Dr. Samuel T. Laffel

2922 Oak Lawn Avenue
Dallas, TX 75219
(214) 219-4325
(214) 526-2267- *fax*

CONSENT TO TREAT

I hereby give consent to Dr. Samuel T. Laffel and Genesis Chiropractic to provide Chiropractic care to myself and/or family. I understand there is a fee for services and understand that the fee is payable at the time services are rendered. I hereby agree to such fees and understand that I am liable for any and all legal fees if collection services are necessary.

Signature: _____ **Date** _____

Witness: _____ **Date** _____

Release and Assignment

I authorize the release of any medical or other information necessary to process claims. I also assign my benefits and request payment of MPC, Medical, Chiropractic, or 3rd party benefits for services to be paid directly to **Dr. Samuel T. Laffel or Genesis Chiropractic** for services rendered. This assignment is irrevocable until all debts on this account have been paid in full.

Signature of insured: _____

Date Signed: _____

“Healing the World. One spine at a time”
Samuel T. Laffel, D.C.