

Designation of Authorized Representative

I _____ do hereby designate FORME Medical and Rehabilitation Kirk Chiropractic (hereafter referred to as “my doctor”) to the full extent permissible under the Employee Retirement Income Security Act of 1974 (“ERISA”) and as provided in 29 CFR 2560-503-1(b)4 to act on behalf to pursue claims and exercise all rights connected with my health care benefit plan, with respect to any medical or other health care expense(s) incurred as a result of the services I receive from the above named doctor/facility. These rights include the right to act on my behalf with respect to initial determination of claims, to pursue appeals of the benefit determination under the plan, to obtain records, and to claim on my behalf such medical or other health care service benefits, insurance or health care benefit plan reimbursement and to pursue any other applicable remedies, all in connection with medical or other health care expense(s) as the result of services I receive from my doctor.

(Patient Signature/ Guardian)

(Patient Printed Name and Guardian)

(Date)