

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In consideration of the medical expenses to be incurred, I, the undersigned, acknowledge that I have insurance and/or employee health care benefits coverage with the above-captioned entity, and I hereby assign and convey directly to **Spinos Family Chiropractic** all medical benefits and/or insurance reimbursements, if any, otherwise payable to me for services rendered by the above-named doctor and clinic. I understand that I am financially responsible for all charges, regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release any and all medical information necessary to process this claim. I further authorize any plan administrator, fiduciary, insurer, or my attorney to release to the above-named doctor and clinic any and all plan documents, insurance policies, and/or settlement information upon written request from the doctor and clinic for the purpose of claiming medical benefits, reimbursement, or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefit claim submissions. To the fullest extent permissible under applicable law and under any insurance policy and/or employee health care plan, I hereby assign and convey to the above-named doctor and clinic any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage with respect to medical expenses incurred as a result of services received from the above-named doctor and clinic. This assignment includes the right to claim medical benefits, insurance reimbursements, and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with the doctor and clinic in any attempts to pursue such claim, chose in action, or right against my insurers and/or employee health care plan, including, if necessary, bringing suit in my name with the doctor and clinic, but at the doctor and clinic’s expense. This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment shall be considered as valid as the original. I have read and fully understand this agreement.

Signature of Insured/Guardian

Date

Terms of Acceptance:

The goal of our office is to enable patients to gain control of their health. To achieve this, we believe communication is the key. There are often topics that are hard to understand, and we hope this document will clarify those issues for you. Please read the below information and if you have any questions, please feel free to ask one of our staff members.

Informed Consent:

A patient who seeks care from a chiropractic physician grants the doctor permission and authority to provide treatment in accordance with chiropractic examinations, diagnosis, and clinical analysis. Chiropractic adjustments and other clinical procedures are generally beneficial and seldom cause complications. In rare cases, however, underlying physical defects, deformities, or pathologies may render a patient more susceptible to injury. The doctor will not provide any treatment or care if he or she is aware that such care is contraindicated. It is the responsibility of the patient to disclose any known conditions and to inform the doctor of any latent pathological defects, illnesses, or deformities that may not otherwise come to the attention of the chiropractic physician. The chiropractic physician provides a specialized, non-duplicative health care service. Your Doctor of Chiropractic is licensed in a specific scope of practice and is available to work in coordination with other health care providers as part of your overall health care regimen. I understand that if I am accepted as a patient by a physician at SPINOS FAMILY CHIROPRACTIC, I authorize the physician and staff to proceed with any treatment deemed necessary. Furthermore, any risks associated with chiropractic treatment will be explained to me upon request.

Acknowledgement:

I have read the notice of privacy practices (HIPPA) and have been provided an opportunity to discuss my right to privacy.

Print Name: _____

Signature: _____

Date: _____