WILCOX FAMILY CHIROPRACTIC, LLC

Signature On File Assignment of Benefits, Financial Agreement and Treatment Consent

- **Release of Information**: Wilcox Family Chiropractic, LLC may disclose all or any part of my medical records and/or financial ledger to any person or corporation, which is or may be liable or under contract with Wilcox Family Chiropractic, LLC for reimbursement for services rendered and any health care provider for continued patient care. Wilcox Family Chiropractic, LLC may also disclose on an anonymous basis, any information concerning my case, which is necessary and appropriate for the advancement of medical science, medial education, medical research, for the collection of statistical data or pursuant to State or Federal Law, statutes or regulation.
- **Financial Agreement:** I agree that in return for services provided to me by Wilcox Family Chiropractic, LLC to pay in full at time of service. If an account is to collections, I agree to pay collection expenses. I understand and agree that if my account is delinquents, I may be charged a service fee, it is understood that the undersigned and/or the patient are primarily responsible for the payment of the bill. Furthermore, by signing below I acknowledge that I have been made aware that there is a $35.00 fee for all returned checks. The parent/legal guardian who brings the child to our facility will be responsible for required payment at the time of service.
- **Appointment Cancellation/Missed Appointment**: There may be a $10.00 charge for not giving a 24-hour notice for appointment cancellations or missed appointments. Missed appointments not only mean a loss of charges and gaps in the schedule, but also represent a lost opportunity to better serve patients who are in need of chiropractic care.
- **Personal Injury/Auto Claims**: Auto claims will be billed to either your auto insurance or to the other parties auto insurance. If the auto insurance company does not pay per claim, but upon settling of the claim all of the medical bills in which you have accrued through Wilcox Family Chiropractic LLC are to be paid to Wilcox Family Chiropractic, LLC. If settlement is received, and the insurance company has not paid outstanding bills, I agree to pay one hundred percent of all outstanding medical bills owed to Wilcox Family Chiropractic, LLC.
- I understand that I am primarily responsible for my account and agree to pay for all services rendered to me through Wilcox Family Chiropractic, LLC. This form is considered a legal binding document and by signing below you the patient, or account holder agree to all of the terms stated in this document.
- **Privacy Plan:** I agree that I have been given the opportunity to read and receive a copy of Wilcox Family Chiropractic's Notice of Privacy Policy.
- **Notice:** Anyone under the age of 18 will not be seen without a parent or legal guardian present unless you are an emancipated minor.
- **Treatment Consent**: By signing below I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to the administrator to perform such procedures upon me, as the doctor deems necessary in the diagnosis and/or treatment.
- **Additional Disclosure Authority**: Please indicate any additional parties we are allowed to speak with regarding your account. (Please Circle)
- Spouse? Name: ____________________________ Yes No Immediate Family? Yes No

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

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Signature of Patient Guardian or Representative Date

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Please Print Name Relationship to Patient

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Date of Birth

Revised June 2013