**cox CHIROPRACTIC care, LLC |** coxchiropracticcare.com

**Assignment of Insurance Benefits/PATIENT FINANCIAL RESPONSIBILITY:** I hereby authorize my insurance company to pay by check made out to and mailed/deposited directly to Clifton Cox, DC, Patricia Cox DC/Cox Chiropractic Care, LLC 207 NW St. James Drive, Port St. Lucie, FL 34983, the chiropractic/medical expense benefits allowable and otherwise payable to me under my current insurance policy, as payment toward the total charges for services rendered; If my insurance company fails to pay or if their payment is less than the fees levied, I agree to pay immediately, any allowable bills for professional services over and above this insurance payment. It is expressly understood that all patients are ultimately responsible for payment for services rendered. **Assignment of Insurance Benefits FOR MOTOR VEHICLE INSURANCE/INJURY:** I hereby assign and transfer to ­­­­­­­­­­­­­­­­­­­­­­­ Clifton Cox, DC, Patricia Cox DC/Cox Chiropractic Care, LLC any and all applicable personal injury protection, medical payments, causes of action, or any other similar insurance benefits relating to the care and treatment provided relating to my automobile accident. Should any insurance company not provide insurance payments as required under Florida Law and the subject policy provisions, I hereby assign to Clifton Cox, DC, Patricia Cox DC/Cox Chiropractic Care, LLC any and all causes of action that exist in my favor against any automobile insurance carrier(s). **X-RAY COPIES:** We can provide a digital copy of your x-rays, which we will email to you or your healthcare provider. Please allow reasonable notice. *FL Statute 456.057:* We do not lend out original films. We do not make copies of films. We do not provide computer discs. **PARENT OR LEGAL GUARDIAN FINANCIAL RESPONSIBILITY FOR A MINOR:** I do hereby accept financial responsibility, as noted above, for the minor patient. **PHOTOCOPY VALID:** A photocopy of this page shall be considered as effective and as valid as the original.

**HIPAA**

**Acknowledgment of receipt of notice of privacy practices:** I acknowledge that I was provided the opportunity to read a copy of the Notice of Privacy Practices and that I have read them and understand them or decline the opportunity to read them. **COMMUNICATION:** I authorize this clinic to contact me via email, voicemail, fax, phone or text message for issues pertaining to my care including protected health information “PHI”, utilizing contact information I provide. **ADVERTISING:** From time-to-time we may contact you for promotional purposes. **YOUR RIGHTS:** We may not condition treatment or require you to sign this authorization and you may refuse to sign it. **EXPIRATION/REVOCATION:** This authorization will not expire but I may revoke it in writing, at any time.

**CONFIDENTIAL COMMUNICATIONS (OPTIONAL):**

If you choose, list ONE person we may discuss your personal health information with **(e.g. spouse/child/friend etc.)**:

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Name & Phone #

**RELEASE OF RECORDS:** I authorize, without notice, the release of any information **pertinent** to my care from Cox Chiropractic Care, LLC, to or from any healthcare provider, insurance company or other third party payer, attorney or other relevant party in order to provide seamless care/accounting.

*“I have read the above statements. I understand them and agree to them.”*

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 **Patient/Parent/Guardian Print Name Signature Date**

**INFORMED CONSENT**

**Procedures**: the doctor will obtain your medical history and may conduct a physical examination, take x-rays and provide treatment whereby the doctor may use his hands to move your joints (chiropractic adjustment) as well as various ancillary procedures such as hot or cold packs, massage therapy, electric muscle stimulation, therapeutic ultrasound, mechanical traction and exercise may also be used. **Risks**: Chiropractic is considered very safe; however, as with any healthcare procedure, complications are possible following a chiropractic adjustment including strain sprain, dislocations of joints or injury to discs nerves or spinal cord and fractures of bone. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck but the risk has been estimated at one in one million and can be even further reduced by screening procedures. A minority of patients may notice stiffness or soreness after the first few days of treatment. Some ancillary procedures could produce skin irritation, burns or minor complications. The patient agrees not to withhold pertinent medical history information. **Alternatives**: Other treatment options which could be considered may include over-the-counter drugs, medical care, hospitalization and surgery, all of which are generally considered less conservative. However, no guarantees with respect to outcomes are express or implied by the doctor/staff. **Consequences:** Delay of treatment may allow formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce joint mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate my condition and make future rehabilitation more difficult. **Consent:** “I have read the foregoing paragraph and discussed with the doctor my questions, if any, and had them answered to my satisfaction. By signing in this box, I state that I understand the risks, alternatives and consequences and I hereby give my consent to undergo the procedures noted above and any recommended treatment I choose.”

**PATIENT SIGNATURE DATE DOCTOR SIGNATURE**

 v.1/1/17