WATSON CHIROPRACTIC CENTER
2711 WEST SR 434
LONGWOOD, FL 32779
(407)774-3311

Authorization to Treat

I _____, hereby authorize the staff of Watson Chiropractic Center to provide me with medical treatment. I agree to inform Watson Chiropractic Center if I have any concerns about my treatment at the time services are being rendered.

We/I _____, the parent(s)/guardian(s) of _____ give Watson Chiropractic Center and its employees the right to treat my son/daughter or legal ward.

Release of Information

The medical records concerning patient care are the property of Watson Chiropractic Center and maintained for the benefit of the patient, the medical staff and the center. I hereby authorize Watson Chiropractic Center to release information and/or copies of my medical records to physicians, any guarantor of payment on my account, insurance companies (and other third-party payors and patient's employer), for which I have assigned benefits for my treatment or care. I authorize the provider to use all available means of communication to transmit such information, including electronic mail or electronic transmissions.
Please initial _____.

Medicare

All patients must check one box in the Medicare section. Please provide your Medicare card at the time of the visit.

- ☒ **I confirm that I am not enrolled in Medicare Part A.**
- ☐ **Medicare part A is my primary insurance**
- ☐ **Medicare part A is my secondary insurance**

Please Initial _____.

Financial Policy

Watson Chiropractic Center will be happy to accept a check as a form of payment. In the unlikely event that your check is returned unpaid, you understand and agree that you will be responsible for the returned check fees. We will discuss our fees with you at any time. In the unlikely event your account is referred to a collection agency, you understand and agree that a service fee will be charged. All patients pay for services in full at the time services are rendered.
Please initial_____.

Assignment of Benefits

The undersigned, whether signing as a patient, representative, or guarantor, hereby authorizes direct payment of any insurance benefits otherwise payable to or on behalf of the patient to Watson Chiropractic Center. I hereby direct the insurer to pay such benefits directly to Watson Chiropractic Center in consideration of the professional services rendered to me or my insured dependent or any insured person designated in my policy. I understand I will be responsible for payment of services not covered and/or denied by health insurance.
Please initial_____.

24 Hour Notice Policy

I agree to notify Watson Chiropractic Center of a change to a scheduled appointment as least 24 hours prior to that appointment.
Please initial _____.

Signature _____ Name (Print)_____Date: _____

Address: _____, FL 32_____

Cell Phone: _____ Email: _____ Home Phone _____

Rev. 1/3/17