

**GARCIA SPINE CENTER
DR. HERB GARCIA
1304 EAST MAIN STREET SUITE A
EASLEY, SC 29640
864-859-5026**

PRIVACY FORMS (BRIEF EXPLANATION)

CONSENT FORM

Required by the government. We may have to share your health information with other doctors, insurance companies, or with members of our staff to run our practice.

You have the right to tell us not to send your records to certain people or insurance companies and that you can make changes to this consent form at anytime.

If you have no questions, please sign below:

Signature of Patient

Authorized Signature

Date

Date

APPOINTMENT REMINDERS & HEALTH CARE INFORMATION AUTHORIZATION

We need to get permission to call you with appointment reminders or, if we need to contact you with information about your treatment or other health information. We want to make sure it's OK to leave you messages on your answering machine or sent you mail.

You always have the right to change your mind about your authorization and if you do not want to sign this it will not affect your treatment or the effort we make to get your claims paid.

If you have no questions, please sign below:

Patient Signature

Authorization Signature

Date

Date

PLEASE READ AND SIGN REVERSE SIDE ALSO →

AUTHORIZATIONS AND RELEASES

NAME: _____ CASE # _____ DOB _____

CONSENT FOR TREATMENT

I, the undersigned, a patient in this office hereby authorize Dr. _____ (and whomever he/she may designate as his/her assistant (s) to administer treatment as he/she deems appropriate.

I, also, certify that no guarantee or assurance has been made to the results that may be obtained.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. However, **I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment...**

Patient's Signature: _____ Date _____ Witness _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the release of any medical information necessary to process my insurance claim (s) and also certify that all insurance information given to the clinic is correct and complete.

Patient's Signature: _____ Date _____ Witness _____

REQUEST FOR PAYMENT OF BENEFITS TO PROVIDER OF CARE

I hereby authorize the _____ Insurance Company/Insurance Administrator to pay by check, and for it to be mailed directly to:

The expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said professional charges. I agree that this office be given power of attorney to endorse/sign my name on any drafts for payment of my bill. **A photocopy of this agreement shall be considered as effective and valid as the original.**

Patient's Signature: _____ Date _____ Witness _____

ATTORNEY REPRESENTATION AND PROTECTION OF BALANCE

I, the undersigned patient am direction my Attorney, _____, to pay any outstanding bills out of my settlement and, in effect, protecting any such balance. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for the doctor's additional protection and consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee. I have been advised that if my Attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but, will require me to make payment on a current status.

Patient Signature: _____ Date _____ Witness _____

CONSENT FOR TREATMENT OF MINOR

I hereby authorize _____, D.C., and whomever he/she may designate as his/her assistant (s), to administer chiropractic care as he/she deems necessary to my _____ (indicate relationship of child)

Patient Signature: _____ Date _____ Witness _____

X-RAY/MEDICAL RECORDS RELEASE

I have requested the release of x-rays and/or records of _____ (patient's name) which are a part of the records at _____ (clinic). In consideration of the foregoing, I hereby release and forever discharge the afore said doctor from any and all responsibility or liability of any kind, nature or character whatsoever arising from any and all responsibility or liability of any kind, nature or character whatsoever arising from said treatment. I hereby acknowledge receipt of said records or request that these records be sent to :

(name)

(address)
Patient's Signature: _____ Date _____ Witness _____