Authorization Form

Patient Name: _____ Account #: _____

Date of Birth: _____

MEDICAL CONSENT: I require evaluation and/or treatment by a physician and hereby consent to and ask for such care. Includes routine diagnostic work, chiropractic manipulation and physiotherapy that my doctor considers necessary. I acknowledge that no guarantees have been make to me regarding the outcome of examinations or treatment. I understand I will not be involved in any research or experimental procedure without my knowledge or consent.

ASSUMPTION OF RESPONSIBILITY: I agree that in consideration of services to be rendered, I obligate myself, assume financial responsibility and agree to pay upon demand to the Sunshine Medical Centers all charges for such services and incidentals incurred. Even though insurance may be filed, I understand that all bills are payable upon receipt and that I, and the insurance company, am responsible for the payment of all services.

- Insurance cards must be provided at the time of service. Failure to present the insurance card will result in full patient responsibility.

ASSIGNMENT OF INSURANCE: I hereby assign direct payment of any medical insurance benefits including Medicare, Medigap, major medical benefits, insurance disability benefits, or injury benefits payable because of liability of a third party organization, and payable to or for the above said patient until account is paid in full.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE: I acknowledge receiving today a copy of the Sunshine Medical Centers' notice of privacy policies. I consent to the Sunshine Medical Centers' use of protected health information as described in the notice for treatment, payment, or health care operations. I understand that I must provide a separate authorization before any other disclosures may be made.

MESSAGES: May we leave a message at the contact number you indicated on your registration form regarding verification of appointment and/or test results? YES ◉ NO ○
If no please specify a number(s) where we may contact you:

PERMISSION FOR DISCLOSURE: I give my permission to disclose my protected health information to the following people:

NAME _____ RELATIONSHIP _____ DOB _____
NAME _____ RELATIONSHIP _____ DOB _____
NAME _____ RELATIONSHIP _____ DOB _____
NAME _____ RELATIONSHIP _____ DOB _____

_____ _____
Signature of Patient or Patient's Representative: *Date*

Printed Name of Patient's Representative: _____

Relationship to Patient: _____