Informed Consent for Examination and Treatment

I (we) hereby consent to the performance of examination and treatment on me or on _____, by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists who may be employed be or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intent this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____.

_____ _____

Patient's Name (Print) Patient's Signature

_____

Date

_____ _____

Witness Relationship or Authority if Not Signed by Patient

Record Release Authorization

Doctor/Hospital _____

Address_____

_____

_____

I Hereby Authorize and Request the Release of my Medical Records to:

South Lake Wellness & Injury Center
2745 Citrus Tower Blvd
Clermont, FL 34711
Phone: (352)241-4111
Fax: (352)241-4113

Thank You in Advance for Your Cooperation.

_____ _____

Patient's Signature Date

_____ _____

Patient's Name (Please Print) Date of birth

_____ _____

If Patient is a Minor Signature of Parent or Legal Guardian Relationship to Patient

_____ _____

Witness to the Above Signatures Please Print Name

OFFICE FINANCIAL POLICY

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under care.

1. If You Do Not Have Insurance: All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed $100 at any time or care may be terminated. Our payment plans make care an affordable part of your family budget.

2. If You Have Insurance: All deductibles and co-payments are expected at the time of service or by an authorized payment plan. We do our best with provide you accurate information from your insurance company. However, our explanation is not a guarantee of benefits. We can **not** guarantee your coverage until we get an explanation of benefits from your insurance company. Your co-insurance balance may not exceed $100 or care may be terminated. Our payment plans make care an affordable part of your family budget.

You are considered a cash patient until you bring in your completed insurance forms, and we qualify and accept your insurance coverage. We do not accept assignment for secondary insurance carriers (unless secondary to Medicare), but will be happy to provide you with a claim form for your secondary carrier.

Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard and of care in this area.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

When your schedule of visits is once per month or longer, you will not be eligible for insurance assignment. Charges for services rendered will be due as they are rendered. We will continue to provide you with an insurance claim form.

If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

Patient's Printed Name: _____

Signature: _____ Date: _____

Finance Counselor: _____ Date: _____

Front Desk: _____ Date: _____

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form with be placed in my patient chart and maintained for six years.

Print Patient's Name	Patient's Signature	Date

Print Parent or Legal Guardian Name	Signature

Print Front Desk Name	Signature	Date

This form will be placed in the patient's chart and maintained for six years. List Below anyone to whom you authorize the practice to release your medical/treatment information.

Name	Relationship
Name	Relationship
Name	Relationship

South Lake Wellness & Injury Center, PL

2745 Citrus Tower Blvd.
Clermont, FL 34711

V: 352-241-4111
F: 352-241-4113

www.SouthLakeWellnessInjury.com

June 21, 2022

RE: Massage Therapy Visits

Effective immediately, any patient scheduling a massage **30 minutes and longer** must sign this agreement. Cancellation notice must be given to our office 48 hours prior to canceling an appointment with our massage therapist. If notice is not given within this time frame, a fee equal to half of the time you have reserved will be applied to your next visit. This is not reimbursable by insurance.

For example:

- If you schedule a 30 minutes massage and don't cancel within an appropriate time as stated above, you will be charged a $25 fee on your next visit.
- If you schedule an hour massage and don't cancel within an appropriate time as stated above , you will be charged a $50 fee on your next visit.

Additionally, no more than one hour may be scheduled with our massage therapist during a visit.

These massage appointments can only be scheduled one month in advance.

Thank you for your understanding.

I acknowledge this policy and will follow these guidelines.

_____ _____

Name Date