Authorization to Release Health Care Information

For Billing, If reporting to your attorney of record; or for reporting to other physicians if any:

I hereby authorize Ocala Chiropractic and Wellness, or assigned staff members, to release information contained in my medical record to any and all insurance carriers from whom I may be due benefits, to my primary care physician or other healthcare providers associated with my treatment, and to my attorney of record (if an attorney is involved):

Signature confirmation if read, understood and agreed: _____ Date: _____

Assignment of Benefits

I hereby instruct and direct that payments for the provided services for me to be sent directly to Ocala Chiropractic and Wellness, Grove Chiropractic LLC, or Schuyler Grove, DC and not to me, my guardians if any, my estate if applicable, or my attorney, regardless of any assignment of benefits my attorney or others may present on my behalf, regardless of the date such other assignment or instruction may be signed by me or presented by others.

- I hereby instruct and direct that payments for health care provided me by Ocala Chiropractic and Wellness, and staff, as reflected in bills for such service that may be presented, as may be due me under terms of a contract of health insurance, or as a result of an action at court, settlement, structured settlement, judgment, verdict or arbitration award which I may receive or be due, be sent directly to Ocala Chiropractic and Wellness, Grove Chiropractic LLC, or Schuyler Grove, DC. This instruction shall be considered irrevocable and shall survive me and my period of care under Ocala Chiropractic and Wellness forever and without exception.
- Regarding only payment for Ocala Chiropractic and Wellness' services to me as reflected in bills presented to me, I hereby rescind any and all assignments of benefit presented by my attorney of any date prior to this date to any party receiving this notice. Also, under all circumstances, I direct and instruct that any monies sent to any party as payment for the services at Ocala Chiropractic and Wellness, following receipt of office bills and or statements, BE MADE PAYABLE SOLELY TO OCALA CHIROPRACTIC AND WELLNESS.

Signature confirmation if read, understood and agreed: _____ Date: _____

Collection Agreement

- I hereby acknowledge that by coming under the care of Ocala Chiropractic and Wellness I personally am ultimately and fully responsible for the payment of all charges or fees for services provided for me, regardless of the contract of insurance, any action at court, any settlement, structured settlement, judgment, verdict or arbitration award which I may receive or be due, or the course or outcome of any dispute regarding same. I also understand that I may be charged a 1.5% monthly interest charge for any patient balances unpaid after 60 days.
- I agree to deliver to Ocala Chiropractic and Wellness any check, draft, or funds that I receive from any source intended as payment for services rendered to me by Ocala Chiropractic and Wellness within 10 calendar days of receipt by me and to be held responsible for 1.5% month-interest accrued for failure to deliver money after 60 days.
- I agree to reimburse Ocala Chiropractic and Wellness (Grove Chiropractic LLC) for all reasonable collection costs it incurs that arise from collection actions it takes against me in the process of settling my account.

Signature confirmation if read, understood and agreed: _____ Date: _____

Appointment Policy

We are sympathetic to urgent situations that may prevent you from keeping a scheduled appointment. We also understand the **rare**, "OOPS! I totally forgot," situation. However, we reserve the right to charge for appointments that are blatantly missed or appointments that are cancelled without notice for at least twenty-four hours. A charge of $30 is our policy. We ask your courtesy in keeping your appointments.

Ocala Chiropractic and Wellness
Schuyler Grove, DC
419 NE 36th Ave
Ocala Florida 34470