



Spinal Center Clinics

2921 West Michigan Avenue
Pensacola, Florida 32526
(850) 434-8880

NOTICE TO INSURANCE COMPANY OF ASSIGNMENT

TO: Insurance Company

Patient Name _____

Date _____

You are instructed to pay directly to the doctor at his office for all professional services rendered to me by his office. This instruction to you is an assignment of my rights under medical coverage to the extent of this bill. Any sum of money paid under this assignment shall be credited to my account and I shall be personally liable for any unpaid accounts for hospital, diagnostic and consultant services.

I hereby authorize the doctor listed below to furnish you the information and evidence in their possession regarding my history and physical condition.

Pay to Doctor:

Patient Signature _____

M.L. Woodruff, D.C.
2921 West Michigan Avenue
Pensacola, FL 32526
(850) 434-8880



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M.L. WOODRUFF, B.A., D.C.
Licenced by the State of Florida
to practice Chiropractic Medicine
Evaluation & Treatment of
Neuro-Musculoskeletal Conditions

Direct Authorization without Assignment of Benefits

Know all men by these present: That the undersigned has made, constituted, appointed and authorized M.L. Woodruff, D.C. to pursue payment from my insurance carrier and any known parties involved with this claim.

Know all men made by these present: That the undersigned has made, constituted, appointed and by those present does hereby make constitute and appoint by way of original or a copy hereof M.L. Woodruff, D.C. and any of its duly authorized agents and employees as and to be the undersigned's true and lawful Attorney for and in the undersign's name, place and stead to endorse any and all checks, draft or money orders which are made payable to the undersigned alone or to the undersigned and the said M.L. Woodruff, D.C. and refer check, money orders or payment chiropractic care, treatment and diagnostic testing of the like which have been rendered by M.L. Woodruff, D.C. at the request or with the knowledge and approval of the undersigned and/or maker of the check, draft, or money order.

This authorization for direct payment should not be deemed an assignment of benefits in that the patient retains al rights to enforce the applicable insurance contract and transfers no right, title or interest in said contract, other than the right to receive direct payment as specified herein above.

The undersigned by these presents does thus give and grant unto the said M.L. Woodruff, D.C. as attorney the full power and authority to do and perform all and every act and thing whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said checks are concerned.

The undersigned does hereby ratify and confirm any and all actions taken by the said Attorney in accordance with this special power of attorney and which the said attorney shall do or cause to be done by virtue of these presents.

In Witness Whereof of undersigned have hereunto set their hands this
_____ day of _____ 200__.

Patient's Name

Date / /

Patient's Signature

Witness to Patient Signature



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Authorization for Release of Medical and/or Psychological Information

I hereby authorize medical and/or psychological/psychiatric records pertaining to me to be disclosed to:

Dr. M.L. Woodruff
2921 W. Michigan Avenue
Pensacola, Florida 32526

I understand that the record department personnel can make no interpretations of the information contained in the records, and that any such interpretation must be requested from the attending physician.

Patient's name

Signature

Today's date

Date of birth

Witness



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NOTICE TO ALL NEW PATIENTS

Our Clinic files insurance as a courtesy to you. In order for us to do this, we require all the pertinent information regarding your insurance coverage by the second office visit. If we have not received the information requested, a cash payment covering previous and present visits will be expected, otherwise we cannot render further treatment.

If you are a self-paying patient, we do not extend credit over the amount of \$50.00. The first office visit must be paid in the full amount.

I understand and agree to my financial obligations as stated above to the Gulf Coast Spinal Center.

Signature _____

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 will be placed in my patient chart and maintained for six years.

Patient Name (please print)

Date

Parent, Guardian, or Patient's legal representative

Signature