Authorization for Exam, X-rays, Treatment and Release of Information

I, the undersigned, a patient in this office hereby authorize Dr. Sean T. Wolfington and/or Dr. Shana L. Sullivan and whomever he/she may designate as his/her assistant(s) to examine me. Examination may include X-rays, if indicated by the exam. X-rays have been proven harmful to the body, and for this reason if you are pregnant, you must tell us.

PREGNANT? YES_____ NO_____

Furthermore, I authorize Dr. Sean T. Wolfington and/or Dr. Shana L. Sullivan and whomever he/she may designate as his/her assistant(s) to administer such treatment as is necessary, which may include Chiropractic Adjustments, and such additional therapy or procedures as are considered therapeutically necessary on the basis of findings during the course of said treatment. I hereby certify that I have read and fully understand the above Authorization for Examination, X-Ray and Chiropractic Treatments, and the reasons why the above treatments are considered necessary, the advantages and possible complications, if any, as well as possible alternative modes of treatment, which were explained to me by the examining doctor. I also certify that no guarantee or assurance has been made as to the results that may be obtained.

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ASSIGNMENT AND AUTHORIZATION

TO: ACTIVE FAMILY CHIROPRACTIC, LLC
P.O. Box 50091
Greenwood, SC 29649

In consideration of your undertaking to treat me I agree to the following:

1. I hereby attest to the accuracy of my medical and/or accident history and further certify that I present myself to Active Family Chiropractic, LLC for evaluation and/or treatment of a health related condition and for no other purpose. I clearly understand that I am totally responsible for payment should the insurance company deny payment or makes payment to me
2. I hereby irrevocably assign to you any right title interest, claim and/or assignment I may have against any insurance company obligated to make any type of payment for your charges, whether based on first party coverage or third party coverage. I authorize and direct payment to you of any sum which may become due under any contract of insurance covering your services.
3. Should any such insurance company fail to make payment, full payment, or prompt payment, of any claim, I hereby assign and transfer to you any cause of action that might exist in my favor against such insurance company, and you shall be substitute in full place instead of me as a Plaintiff in any litigation arising out of such cause of action. Any and all charges, fees and/or expenses incurred from any payment/collection will be charged to the insurance company
4. I understand that you will make all reasonable efforts to collect any insurance benefits under any such policies before you proceed with any attempts to collect sums not paid by the insurance company from me
5. You are authorized to release and/or request any information you deem appropriate concerning my physical condition, treatment to or from and/or historical information that may be pertinent to my health condition from any insurance company, attorney, adjuster or doctor. This may be done in order to process any claim for reimbursement for any charges incurred by me or any services rendered.
6. All documentation no matter how requested or received will be conveyed with all possible security and confidentiality. The patient's information shall remain secure and confidential until statutory limitations of South Carolina are met, then properly disposed by destruction or incineration.
7. A photo static copy of this authorization shall be considered as effective and valid as the original.

Patient Signature_________________________________ Date_________________

Printed Patient Name:________________________ Witnessed by:______________________