FLEX MEDICAL CENTERS
CHIROPRACTIC SOLUTIONS
7556 Lake Worth Road, Suite 103
Lake Worth, FL 33414
561-855-0099

INFORMED CONSENT FOR CHIROPRACTIC CARE AND POLICIES

I, ____ (Patient), hereby give permission and authority to FLEX MEDICAL CENTERS LLC, its physicians and associates, to provide care to the above named patient and to render such care including chiropractic, therapeutic procedures and instruments, diagnostic procedures, acupuncture and medical treatment as may be deemed necessary or advisable in the diagnosis or treatment of this patient and I direct Flex Medical Centers LLC, its associates, agents and employees to follow the doctor's instructions and direction. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to results of treatment, tests or examination. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts known, is my best interest. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.
I also hereby declare that I have not been solicited and personally choose to seek any and/or all treatment rendered by Flex Medical Centers LLC, its physicians and associates, and do so of my own free will.

GUARANTEE OF PAYMENT: In consideration for the services to be provided to the patient, the undersigned promises to pay Flex Medical Centers LLC and any physician providing services during the period of this treatment, all amounts legally due and not paid by insurance, Medicare, a third party payer, or other source on my behalf for services rendered, which **payment shall be due at the time of treatment**. In the event it is necessary to refer this account to a collection agency or an attorney, the undersigned further agrees to pay all reasonable costs of collection, including reasonable attorney fees. If more than one individual executes this agreement their liability shall be joint and several.

INSURANCE PAYMENTS: I understand that my **health insurance company may send payments and paperwork** relating to my services rendered **directly to me**. I further understand that **it is my responsibility to bring in those insurance payments and**

paperwork to the office to reconcile my account(s) or **to personally make payment** on behalf of services rendered to me to **avoid any further action on my account(s**).

ASSIGNMENT OF BENEFITS, IF APPLICABLE: In consideration for the services rendered or to be rendered, I hereby irrevocably assign and transfer to Flex Medical Centers, LLC and to any associate or physician providing services, all rights, title and interest, to the benefits payable by any and all insurance or third party payers that are or may be liable for the services rendered, to the patient. This irrevocable assignment and transfer shall allow Flex Medical Centers, LLC or those associates or physicians, to pursue any such right or recovery. Even though I have made this assignment, I understand that Flex Medical Centers, LLC has the right to demand payment in full from me and the liability shall remain joint and several as between me and all guarantors and third party payers, and **I am responsible for payment for any charges not paid for me on my behalf.**

MEDICARE / MEDICAID ASSIGNMENT OF BENEFITS, IF APPLICABLE: I hereby assign to Flex Medical Centers LLC or any associates physicians providing services to me, any Medicare or Medicaid benefits which may be available to pay for those services provided by Flex Medical Centers LLC or any associates or physicians. I certify that the information given by me in applying for payment under the Title XVII of the Social Security Act is true and correct.

X______________________________________ ______________________________________
Patient Signature Date

To be completed by patient's representative if patient is a minor or physically or legally incapacitated.

______________________________________ ______________________________________
Print Representative's Name Relationship to Patient

X______________________________________ ______________________________________
Signature of Representative Date

WITNESSED BY:

______________________________________ ______________________________________
Witness – Print Name Date