



# Pitts Chiropractic Clinic

## Patient Authorization Form

### Your Financial Responsibility

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Pitts Chiropractic Clinic and/or its affiliated entities for any charges not covered by health care benefits. I also understand that if I am not insured and that I am a self-pay patient I am financially responsible for any charges. It is my responsibility to notify Pitts Chiropractic of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by Pitts Chiropractic Clinic and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand by signing this form that I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

### Authorization for Treatment

I hereby authorize the Doctor to treat my condition, as he deems appropriate through the use of manipulation, physiotherapy, massage therapy, examination, and x-rays throughout the spine.

### Assignment of Insurance Benefits

I, \_\_\_\_\_ hereby assign all insurance benefits to which I am entitled, including, but not limited to, Personal Injury Protection (PIP), and/or Medicare benefits to Dr. Jeffrey Pitts, Dr. J.M. McPherson, Dr. Samuel Cohen, Dr. Travis Wilemon, Dr. Sonja Lonadier, and Dr. Jenna Taylor in exchange for medical treatment and/or medical services rendered to the undersigned by the aforementioned Doctors.

### Authorization to Release Information

This authorization is given pursuant to Florida Statute 456.057 and HIPAA regulations. I understand that Florida Statute 456.057 (10) makes it clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical record without the expressed consent of the patient or the patient's legal representative. I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related services to Pitts Chiropractic, the Health Care Financing Administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company or other entity if requested. The original authorization will be kept on file by the organization. A photocopy of this assignment is considered as a valid original. This assignment will remain in effect until revoked by me in writing.

Print Name of Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_

Signature of Parent/Guardian if minor: \_\_\_\_\_

Date Signed: \_\_\_\_\_

Date Consent Expires: \_\_\_\_\_



**Dr. Jeffrey Pitts, Dr. J.M. McPherson, Dr. Samuel Cohen, Dr. Travis Wilemon, Dr. Sonja Lonadier, Dr. Jeanna Taylor**  
**Address:** 801 NE 25<sup>th</sup> Avenue 34470      **Phone:** 352-732-0200      **Fax:** 352-732-2623

Pitts Chiropractic Clinic  
801 N.E. 25th Ave.  
Ocala, FL 34470  
352-732-0200

**MISSED APPOINTMENTS FOR MASSAGE THERAPY**

If you fail to show up for this appointment time it will affect:

1. Your treatment plan and recovery time
2. Another patient needing that time from being scheduled
3. The massage therapist will not be paid for the lost appointment.

Effective immediately there will be a \$20.00 charge for a missed/no show 30-minute massage appointment and \$40.00 for a missed/no show 60-minute massage appointment. This charge is NOT covered by your health insurance. To prevent this fee, a **minimum** of a two-hour notice is needed.

I \_\_\_\_\_ understand that if I fail to appear for my scheduled massage appointment, I will be charged a fee of \$20.00 or \$40.00, which is not covered by my health insurance and will be my responsibility.

Patient's signature \_\_\_\_\_ Date \_\_\_\_\_

Witnessed \_\_\_\_\_ Date \_\_\_\_\_

## INFORMED CONSENT TO CHIROPRACTIC CARE

*Dr. Jeffrey G. Pitts*  
*Dr. J.M. McPherson*  
*Dr. Samuel M. Cohen*  
*Dr. Travis R. Wilemon*  
*Dr. Sonja Lonadier*  
*Dr. Jeanna Taylor*

**801 N.E. 25TH AVE.**  
**OCALA, FL 34470**  
**352-732-0200**

**Patient: Please discuss any questions or concerns with the Doctor before signing this consent.**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above.

I have had the opportunity to discuss with the doctor and/or with other office or clinic personnel the purpose and benefits of the chiropractic adjustments and other treatments outlined below. Alternatives to treatment have been reviewed.

Though chiropractic adjustments and treatments are usually beneficial and seldom cause any problem, I understand and am informed that there are some risks to treatment. Risks include, but are not limited to, fractures, disc injuries, strokes, dislocations and sprains.

I understand that chiropractic is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the chiropractic treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of  
Patient \_\_\_\_\_ Date \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_  
(If patient is a minor)

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Pitts Chiropractic Clinic**  
**801 NE 25<sup>th</sup> Ave.**  
**Ocala, FL 34470**

**AUTO PATIENTS**

1. The state of Florida is a “No-Fault” state. This means we must file with your automobile insurance company.
2. Your insurance company will send you a “PIP” or “No-Fault” application. They will not consider payment on your claim until they have this completed and returned to them. It is your responsibility to do this in a timely fashion.
3. If your insurance has a deductible or does not pay at 100%, you are responsible for this amount.
4. If you have health insurance that may pick up the amount not covered by your auto insurance please provide us with a copy of your health insurance card so we can verify your benefits.
5. If you obtain an Attorney at any time during your treatment with our office please let us know his/her name and address. If you change Attorney’s at any time please let us know.
6. If we accept a “Letter of Protection” from your Attorney, it is your responsibility to contact us at the time of your settlement to find out what your account balance is. If your case does not settle, or if your Attorney no longer represents you the “Letter of Protection” becomes null and void and you are responsible for the balance on your account.
7. It is very important for you to follow through with the recommended treatment plan. If you are unable to keep your appointments, please let your Doctor know.

I have read and understand the above statement.

Patient Name \_\_\_\_\_

Patient Signature \_\_\_\_\_

Parent or Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

CHIROPRACTIC PHYSICIANS

TELEPHONE (352)732-0200  
Fax (352)732-2623

*Dr. Jeffrey G. Pitts*  
*Dr. Samuel M. Cohen*  
*Dr. J.M. McPherson*  
*Dr. Travis R. Wilemon*  
*Dr. Sonja J. Lonadier*  
*Dr. Jeanna Taylor*

801 Northeast 25<sup>th</sup> Avenue  
Ocala, Florida 34470

DATE: \_\_\_\_\_

To Whom It May Concern At: \_\_\_\_\_

I \_\_\_\_\_ Request the release of my benefit information to  
Dee Fonley, at Pitts Chiropractic due to my car accident on \_\_\_\_\_.

My Claim # is \_\_\_\_\_ . Thank You

SIGNATURE \_\_\_\_\_

Please fax or phone information to Dee Fonley

Phone # (352) 732-0200 or Fax # (352) 732-2623

**Chiropractic Physicians**  
**Dr. Jeffrey G. Pitts**  
**Dr. Samuel M. Cohen**  
**Dr. J.M. McPherson**  
**Dr. Sonja J. Lonadier**  
**Dr. Travis R. Wilemon**  
**Dr. Jeanna Taylor**

**801 N.E. 25th Ave.**  
**Ocala, FL 34470**  
**Telephone# 352-732-0200**  
**Fax# 352-732-2623**

**DOCTOR'S LIEN**

To:

RE: Reports and Doctor's Lien

I do hereby authorized the above indicated doctor to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, and prognosis of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said indicated doctor such sums as may be due and owing him for medical services rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect said indicated doctor. I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgement or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills for services rendered me and that this agreement is made solely for said indicated doctor's additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgement, or verdict by which I may eventually recover said fee.

Date: \_\_\_\_\_ Patient's Signature: \_\_\_\_\_

**Chiropractic Physicians**  
**Dr. Jeffrey G. Pitts**  
**Dr. Samuel M. Cohen**  
**Dr. J.M. McPherson**  
**Dr. Sonja J. Lonadier**  
**Dr. Travis R. Wilemon**  
**Dr. Jeanna Taylor**

**801 N.E. 25th Ave.**  
**Ocala, FL 34470**  
**Telephone# 352-732-0200**  
**Fax# 352-732-2623**

Date Mailed:

Attorney:

I, \_\_\_\_\_ give the above named attorney my permission to  
(Patient's name)  
send to Dr. Jeffrey G. Pitts, Dr. Samuel M. Cohen, Dr. J.M. McPherson, Dr. Sonja  
Lonadier, or Dr. Travis Wilemon, Dr. Jeanna Taylor, located at 801 N.E. 25th Ave.  
Ocala, FL 34470-6319 a letter of protection.

This letter will serve as a guarantee of payment to the above named doctor for all my  
medical bills due at the time of my settlement.

I also understand if there is not a settlement I will be fully responsible for the payment of  
all my outstanding medical bills.

This gives my permission to release any information regarding the status of my case.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_