PRO HEALTHCARE

1948 NE 123rd Street | Suite 107
North Miami | FL 33181

T | 305.891.2520
F | 305.891.5754

Authorizations and Releases

NAME: _____ FILE #: _____

❑ **Office Policy Regarding Payment for Services & Insurance Reimbursement**: I understand and agree that health insurance policies are an arrangement between an insurance company and myself. Furthermore, I understand that the Pro Healthcare will prepare any necessary reports and forms to assist me in collecting from my insurance company, and that any amount authorized to be paid to Pro Healthcare., will be credited towards my account upon receipt. However, I clearly understand and agree that ALL SERVICES RENDERED ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT, including payment of any applicable insurance deductible and/or insurance co-payments. I also understand that if I suspend or terminate my care and treatment prior to the doctor releasing or discharging me from care, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature:_____ Date:_____/_____/_____ Witness:_____

❑ **Authorization to Release Medical Information**: I authorize the release of any medical information necessary to process my insurance claim(s). I also certify that all insurance information given to this healthcare provider is correct and complete.

Patient'sSignature:_____ Date:_____/_____/_____ Witness:_____

❑ **Consent for Physician to Proceed With Treatment**: Although extremely rare, there are risks of being treated with physical therapy, massage therapy, rehabilitation and chiropractic, including sprains, strains, fractures, herniations, burns, bruises, strokes and even death (1 in 5.85 million manipulations). I understand that if I am accepted as a patient by the physicians of the Pro Healthcare, I am authorizing them to proceed with any examination & treatment that may be necessary. Any risks regarding examination & treatment have been discussed and explained to my satisfaction and I understand the doctor feels the benefits outweigh the risks.

Patient's Signature:_____ Date:_____/_____/_____ Witness:_____
Parent or Guardian's
Signature Authorizing & Consenting To the Care of a Minor:_____

❑ **Authorization to Release Healthcare/Medical Records:** I, _____ hereby authorize any person to whom this authorization is presented, either in person, by mail, by fax or otherwise; to furnish the Pro Healthcare / Charles Srour, D.C. ANY AND ALL MEDICAL RECORDS, MEDICAL REPORTS, X-RAYS OR OTHER DIAGNOSTIC TEST REPORTS & FILM concerning my present or past health condition/injury or general health status.

Patient's Signature:_____ Date:_____/_____/_____ Witness:_____

❑ **Limited Power Of Attorney To Endorse Checks**: I agree that this office and any of its duly authorized agents and employees be given power of attorney to endorse/sign my name on any and all checks, drafts, money orders, unpaid insurance claims or affidavits, **which are payable to me for professional services rendered to me by Pro Healthcare/ Charles Srour, D.C.**. The undersigned by these presents does thus give and grant this limited power of attorney to the above named office or doctor the full power and authority to do and perform the intents and purposes as the undersigned might or could do if 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 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.

Patient's Signature:_____ Date:_____/_____/_____ Witness:_____

❑ **PIP Authorization / Protection of Balance Due / Assignment of Benefits**: I, hereby authorize Pro Healthcare. and its Associated Physicians, to provide my attorney or insurance adjuster with whatever records or reports are needed to understand the nature and extent of my injury, the recovery process and what effects, if any, the injury will have on me in the future. I understand that you recognize my need for professional help and treatment and are willing to do so even though I do not have, at this time, sufficient funds to pay for same. Notwithstanding the foregoing, I will remain liable for all treatment performed though the date of termination of treatment. In an effort to see that you are paid in the future for you professional services, I hereby authorize my attorney or insurance adjuster to pay any amount to you to you from the proceeds of the settlement or judgment. I fully understand that I am directly responsible to you regardless of the outcome of any legal proceedings, for all bills for services rendered, provided they are reasonable and customary, and that payment of the same is not contingent on any settlement, judgment or verdict that I may ultimately obtain or receive. I hereby give lien to said office against any and all insurance benefits, any and all proceeds of any settlement of my rights and benefits to the extent of the Office's services provided. **As part of this assignment of rights and benefits ! hereby instruct the insurance carrier that in the event the medical benefits are disputed for any reason, including reasonableness and or medical necessity, that the amount of benefits claimed by Pro Healthcare,. and its Associated Physicians, is to be set aside and not disbursed until the dispute is resolved.** Additionally, I hereby authorize Pro Healthcare. and its Associated Physicians, to request to receive copies of any and all litigation / settlement statements between me the patient and my lawyer(s) are hereby authorized to disclose the same to Pro Healthcare. and its Associated Physicians, without further authorization required. I hereby make and declare these instructions herein contained to be irrevocable.

Patient's Signature:_____ Date:_____/_____/_____ Witness:_____

Last updated: July 30, 2003

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Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent to PRO HEALTHCARE, to use and disclose protected health information (PHI). About me to carry out treatment, payment and healthcare operations (TPO).

PRO HEALTHCARE'S Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. PRO HEALTHCARE, reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to PRO HEALTHCARE at 1948 NE 123 Street # 107 North Miami, Fl 33181.

With this consent, PRO HEALTHCARE may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, PRO HEALTHCARE may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, PRO HEALTHCARE may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that PRO HEALTHCARE restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to PRO HEALTHCARE'S use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, PRO HEALTHCARE may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian

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RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGMENT FORM

I_____ have read a copy of
(Patient's Name)
Pro Healthcare's Notice of Patient Privacy Practices.

_____
Signature of Patient or Legal Guardian

_____
Date