Tampa Bay Spine & Sports Medicine
32815 U.S. Hwy 19 N.
Palm Harbor, FL 34684

Assignment of Insurance Benefits

I hereby authorize payment to be made directly to Tampa Bay Spine & Sports Medicine, LLC. /Eric J. Nye, D.C., P.A., of all benefits which may be due and payable under insurance coverage. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I will remain financially responsible to Tampa Bay Spine & Sports Medicine, LLC. / Eric J. Nye, D.C., P.A.

Authorization to Release Medical Record Information

Tampa Bay Spine & Sports Medicine, LLC./Eric J. Nye, D.C., P.A. is hereby authorized to disclose all or any part of the medical records to such insurance companies, organizations, or agencies as may be responsible for payment rendered by Tampa Bay Spine & Sports Medicine, LLC./Eric J. Nye, D.C., P.A. This authorization I give with full knowledge that such disclosure may contain information of a confidential nature and may result in a denial of insurance coverage for services rendered by said Tampa Bay Spine & Sports Medicine, LLC./Eric J. Nye, D.C., P.A. The undersigned certifies that He/She has read and understands each of the above paragraphs and is the patient or responsible party with the power to execute this document and accept these terms.

- Signature of Patient or Responsible Party:_____

HIPPA

I have read and understand how my Patient Health Information (in provided HIPPA form) will be used and I agree to these policies and procedures.

- _____ Initial _____Date

Consent to Evaluate and Adjust a Minor

I, _____, being the parent or legal guardian of_____

Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

- _____ Initial _____Date

Pregnancy Release

This is to certify to the best of my knowledge, I am not pregnant. The above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

* Date LMP: _____ _____Initial _____Date

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Consent to Treatment

I hereby request and consent to the performance of Primary Care, Chiropractic Manipulation, Physical Therapy, Sports Medicine procedures, Manual Therapy techniques including various modes of physical therapeutic modalities and procedures and diagnostic X-rays, where warranted, on me (or on the patient named below, for whom I am legally responsible) by the Doctors on staff named below and/or other licensed Doctors of Chiropractic Medicine, A.R.N.P., and/or Doctor of Osteopathic Medicine, Medical Doctor who now or in the future work at the clinic or office listed below.

I have had an opportunity to discuss with the doctors on staff named below the nature and purpose of services provided at Tampa bay Spine & Sports Medicine, LL. I understand that results are not guaranteed.

Radiographs: ionizing radiation can be harmful to a fetus for those who are pregnant or might be pregnant.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. The doctor named below has additionally explained the risks associated with my refusal of treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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.

Signature of Patient or Responsible Party: _____

Patient/Guardian Signature_____ Date _____