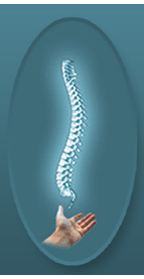

Parris Family Chiropractic

Put Your Health in Our Hands

864-949-9696 | 12301 Greenville Highway, Lyman, SC 29365 | www.parrisfamilychiropractic.com

AUTHORIZATION FOR EXAM, X-RAYS, TREATMENT AND RELEASE OF INFORMATION

I, the undersigned, a patient in this office, hereby authorize Dr. Nikki P. Brown (and whomever she may designate as their assistants) 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. Nikki P. Brown 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, the reasons why the above treatment is considered necessary, its advantages and possible complications, if any, as well as possible alternative modes of treatment, which were explained to me by Dr. Nikki P. Brown or the examining doctor. I also certify that no guarantee or assurance has been made as to the results that may be obtained.

ASSIGNMENT AND AUTHORIZATION

To: **Parris Family Chiropractic**
12301 Greenville Hwy
Lyman, SC 29365
864-949-9696

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 Parris Family Chiropractic 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 my 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 the first party coverage or third party coverage.
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 changed 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 request any information you deem appropriate concerning my physical condition or treatment to or 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. A photostatic copy of this authorization shall be considered as effective and valid as the original.

DATE: _____ SIGNED: _____

WITNESSED: _____ Printed Patient Name: _____